



THE MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—9TH YEAR.

SYDNEY: SATURDAY, APRIL 8, 1922.

No. 14.

“ALLENBURY’S” PRODUCTS

We are pleased to announce to members of the medical profession that the following stocks of Allen & Hanburys' Products are now available:

MALTED FOOD, No. 3, for infants from seven months of age.
Bynin Amara, Byno Hypophosphites, Byno Plasma, Byno Phosphates and Byno Hæmoglobin.

MEDICATED PASTILLES: No. 29, Rhatany and Cocaine; No. 44, Menthol and Cocaine.

PASTILLES, in 2 oz. and 4 oz. tins: Black Currant, Glycerine and Black Currant and Glycerine.

BYNOGEN.

UMBROSE: A Specially Prepared Barium Meal for X-Ray Diagnosis.

Supplies of the above are now coming forward regularly.

ALLEN & HANBURY'S (Australasia) Ltd.
13, MARKET STREET, SYDNEY

Intestinal Infections

resulting from bacterial disturbances can be promptly relieved and controlled by the use of

Dimol

as described by Captain Ainslie Walker in his brochure

"Intestinal Disinfection" (1)

The use of intestinal disinfectants has been justly discredited, owing to the fact that, hitherto, it has been impossible to administer anything which was at once efficient and non-toxic.

Take the case of Salol, the best available for many years. The dose is five grains (more is unsafe); dissolve this in a quart of water (the average residual fluid of the intestinal tract of an adult) and you get a solution which is too weak to destroy even the most attenuated organisms.

Compare this with Dimol. The dose recommended is two to four pulverettes, say three. Each pulverette contains one grain Dimol, and Dimol is thirty-five times more efficient as a bactericide than

Phenol, the active principle of Salol (see test); that is to say, in administering three Dimol Pulverettes, the patient is receiving the bactericidal equivalent of 105 grains of Phenol. Moreover, it is not absorbed, being voided with the faeces, unchanged, after doing its work.

When we are able to repeat this dosage four or five times a day without affecting the appetite or digestion and without action on the mucosa, we can readily understand the excellent results which are obtained by the administration of Dimol in non-amebic dysentery, typhoid, arthritis, chronic ulcerative colitis, intestinal putrefaction, fermentation, auto-intoxication, &c.

"Examination for phenol in the urine after a week's course of treatment gives a negative result. Tests made for us confirm a co-efficient of 35.0 and the freedom from toxicity claimed by the manufacturers."—"The Lancet," April 9, 1921.

BACTERIOLOGICAL TEST (Rideal-Walker Method)

Sample	Organism	Co-efficient
Dimol	<i>Bacillus typhosus</i>	35.0
Phenol	<i>Bacillus typhosus</i>	1.0
Salol	<i>Bacillus typhosus</i>	0.5

DIMOL has been specially prepared for the Medical Profession in the form of Pulverettes (A coated and B uncoated), in bottles of 500, 100 and 50, and as a palatable syrup for infants and little children in bottles of 16 oz. and 4 oz.

(1) Copies may be obtained from Angus & Robertson, Ltd., Sydney and Whitcombe & Tombs, Auckland, N.Z.

THE ANGLO-FRENCH DRUG CO., LTD., 238a Gray's Inn Road, London, W.C.1.

LITERATURE, PRICE LISTS AND SUPPLIES

Obtainable from all Wholesale Druggists throughout the several States or from the

AUSTRALASIAN AGENTS: MESSRS. MACLAY BROTHERS, B.M.A. BUILDINGS, SYDNEY, N.S.W.

THE MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—9TH YEAR.

SYDNEY: SATURDAY, APRIL 8, 1922.

No. 14.

Table of Contents

	PAGE.		PAGE.
ORIGINAL ARTICLES—		ABSTRACTS FROM CURRENT MEDICAL LITERATURE—	
"An Address," by FOURNESS BARRINGTON, F.R.C.S.	373	Pathology	390
"An Address," by R. G. SCOTT, M.B., C.M. . . .	377	Pædiatrics	391
"The Prevention of Tuberculosis," by ROY C. MERRYWEATHER, M.R.C.S., L.R.C.P. . . .	379	BRITISH MEDICAL ASSOCIATION NEWS—	
"Routine of a Syphilis Clinic," by W. J. BEVERIDGE, M.D., L. & L.M.R.C.P., L. & L.M.C.S. . .	382	Annual Meetings—	
REPORTS OF CASES—		New South Wales Branch	392
"A Case of Xanthoma Diabeticorum," by G. R. HAMILTON, M.B., CH.M.	385	Tasmanian Branch	396
REVIEWS—		Medico-Political: The Prescription of Hospital Pharmacopœia Mixtures	397
The Secrets of Ancient Egypt	386	Notices	397
MEDICAL ART CALENDAR	386	CORRESPONDENCE—	
LEADING ARTICLES—		The Metric or the Imperial System	397
The Future Medical Profession	387	BOOKS RECEIVED	398
THE WEEK—		MEDICAL APPOINTMENTS	398
The Delinquent Child	388	MEDICAL APPOINTMENTS VACANT, ETC. . . .	398
Acute Cerebellar Encephalitis	389	MEDICAL APPOINTMENTS: IMPORTANT NOTICE	398
Australian Army Medical Corps	389	DIARY FOR THE MONTH	398
		EDITORIAL NOTICES	398

An Address.¹

BY FOURNESS BARRINGTON, F.R.C.S. (ENG.),

Retiring President of the New South Wales Branch of the British Medical Association.

My first duty in returning to your hands the trust which you so generously placed in mine a year ago, is to express my great appreciation of the kindness, courtesy and help I have invariably received from the Council and the members of the Branch—a support without which it would have been impossible to maintain the dignity of the chair which I am about to demit. No President could have had a more loyal and enthusiastic Council than I have had and I am indebted to its members for their able assistance and wise deliberations in all matters concerning our welfare.

I feel that we owe a special debt of gratitude to the activity and courtesy of those gentlemen who have filled the secretariat and to them I tender our grateful thanks. We must not forget, however, how much our prosperity is due to the masterly way in which our financial affairs are managed. For many years this department has been under the

care of one who combines great geniality of disposition with exact business principles and it is not too much to say that his excellent work and unvarying kindness have insured our Treasurer our warmest regards.

The work of the Branch grows rapidly year by year and serving on the Council is no longer a sinecure. This you may to some extent understand by looking at the list of the standing Committees and the frequent meetings, which necessitate the spending of many hours in this room.

Registration and Supervision of Midwives.

My term of office has been one of more or less placid calm. The special feature that has marked it, was the carrying out of the expressed wish of the members that the Council should request the Government to introduce a bill for the registration and efficient supervision of midwives. We, as a Council, by deputation to the Minister of Public Health, claimed the urgent need for such long-delayed legislation, advocating a special Midwives Board and a high standard of examination and offering the assistance of the whole of our organization.

The passing of a suitable Midwives Act must infallibly lead to a diminution of septic deaths and septic illnesses in child-birth and ill-health in the after lives of mothers and children. The fact that

¹ Delivered at the Annual Meeting of the New South Wales Branch of the British Medical Association on March 31, 1922.

the Branch has intervened in a very important matter of public health, with, we hope, final success, induces me to ask you to pursue the same subject a little further.

Obstetric Mortality and Morbidity.

We know how unduly high the death-rate in child-bed stands. There is in New South Wales, guided by the figures for the last twenty years, a mortality rate from puerperal fever of 2.1 per thousand registered births, while the death-rate from puerperal fever and accidents of child-birth is 5.7 per thousand registered births and in the metropolitan area reaches seven per thousand registered births. This is a much higher mortality rate than obtains in any other Australian State and in other parts of the Empire.

Much as the midwife has been compelled to play the part of the scapegoat, she cannot be saddled with the whole of this unfortunate state of affairs. If the medical men of this State are responsible for any part of this excessive mortality—and there is, unfortunately, no reason to doubt it—it is obviously the duty of the profession as a whole to spare no pains to remove such a reproach.

I purpose this evening to arrive at some way of accounting for this blot on our escutcheon and then to consider the best way to diminish these black figures in the future.

None of us can have any doubt that, if the necessary precautions are taken, puerperal septic disease can be largely abolished in practice. It is also a fact beyond gainsaying that medical men, who are responsible for a large proportion of these unfortunate events, are very anxious to do their very best for their patients. The occurrence of puerperal sepsis in the practice of a conscientious man is a horrible shock to him. It causes him acute mental distress and sleepless nights. This anxiety as to the result of every case he attends is simple misery and must in the end take years off his life.

Then why do not medical practitioners prevent the occurrence of puerperal sepsis in their obstetric work? Why do they not put into practice the precise principles which have been shown in our obstetric hospitals to be completely adequate?

As a matter of fact, there are two causes for this failure. It is of no use trying to shut our eyes to them. One is that there is too much meddlesome interference with a natural process and the other is that proper regard to the principles of asepsis and antisepsis, when interference is indicated, is not considered of the same vital importance as in surgery.

These two main reasons not only explain the unduly high maternal mortality, but also the excessive morbidity, for the wide-spread effects of non-lethal infections constitute an incalculable drain on the economic resources of this young nation and leave a vast army of crippled, inefficient women defeated early in life's struggle, branded with ill-health and sterility through no fault of their own.

The trauma inflicted by untimely interference in labour, be it too early or too delayed, explains the excessive proportion of dead-born infants (we may

infer at least 3% of viable fœtuses) and infants dying in the first week of life (at least 2%). The fœtuses are killed during labour or die soon after birth as the result of head injuries. "White asphyxia" in infants that cannot be resuscitated is of this nature; there is the *post mortem* evidence of tears of the *tentorium cerebelli* and cerebral hæmorrhage. Nor must we forget the infantile morbidity, for the victims of the minor casualties survive and are later handicapped by diseases of the central nervous system, *e.g.*, Little's disease, infantile paraplegia and hemiplegia, mental deficiency, deaf-mutism, speech defects and so on.

The Need for an Improved Obstetric Status.

Now if these views are correct, the evil results of practice must be due to some radical defect in the teaching. May we consider how far the teaching of obstetrics in this school falls short of what it should be?

At present in our University, the student is required "to attend twelve cases of child-birth and a course of lectures in obstetrics (forty-six to forty-eight in number) under such supervision as may be approved by the Medical Faculty." All will agree that such provision is totally inadequate to the vital importance of the subject.

It will generally be conceded that 90% of our graduates will ultimately be general practitioners and that obstetrics will become the backbone of their work. Alone and depending on their own knowledge, manual skill and presence of mind, they will have to carry to a successful issue what may be a simple physiological process or one which, becoming pathological in the highest degree, may tax their resources to the utmost.

Applying the doctrine preached with vigour by social reformers which is becoming more universally recognized—the greatest good to the greatest number—obstetrics should receive a proper academic status by the endowment of a chair in this, the third largest medical seminary in the Empire, and a reasonable part of the medical curriculum should be set aside for the efficient training of the student in this department. This can now be readily done, since two terms have been recently added to the period of study. In other centres of medical teaching, obstetrics has, after a long and hard struggle, gained the position it now occupies on a level with the sister branches of medicine and surgery. The great importance of a sound knowledge of obstetrics and the acquisition by the student of practical experience under skilled supervision has been strongly inculcated by the recommendation of the General Medical Council and is being given a fuller measure of recognition year by year in the various teaching centres. Sir Halliday Croom, for many years Professor of Midwifery in the University of Edinburgh, of world-wide fame as one of the greatest living teachers of the subject, enunciates a great truism: "Obstetrics can never be relegated to a second place in the curriculum."

There are many currents in the academic pool; it is to be hoped that currents in the public interests

will prevail and that the Medical Faculty will urge the Senate to raise the science and art of obstetrics to that high level in our curriculum which is the right of this most vital subject.

My experience as a teacher has proved to me that the time at our disposal is totally inadequate. A careful review of the whole subject cannot be squeezed into forty-eight lectures. It is hardly necessary to point out that in obstetrics, the practitioner is brought face to face with a considerable number of complicated cases in which two lives may suddenly become jeopardized and the mother exposed to risk of permanent damage and depreciation. Take, for example, such complications as hæmorrhage—accidental, unavoidable, *post partum* and that associated with abortion—eclampsia, transverse presentations, impacted breech cases, ruptured uterus, hydrocephalus, prolapse of the cord. Each of such conditions must be dealt with *sui generis* as they arise and they may be classed as the dramatic incidents of private obstetric practice which the attendant must treat at once, unaided and alone.

They cannot be treated on general principles, like many medical and surgical cases, and it is impossible for the practitioner to go home and consult some authoritative work. This being so, it is essential the medical student should be equipped with a sound working knowledge of obstetrics.

The Value of the Systematic Lecture.

It has for many years been a prominent feature in the Scottish Universities that in their medical curriculum they have given an honourable place to the systematic teaching of obstetrics. My belief in the outstanding importance of the systematic lecture as the most essential foundation of a scientific knowledge of obstetrics is whole-hearted. A well-arranged, well-digested course of lectures, when delivered by one who is a recognized authority on the subject, will impart to the student a groundwork for practice which far exceeds the knowledge gleaned from books in the time at his disposal. Such a one can seize upon essential principles, omit adventitious details and present them with a vividness that cannot fail to impress. Moreover, he can appeal to the ear and eye at the same time and clearly demonstrate every important point by model, by specimen or by diagram. Then there is the influence of the living voice; an earnest voice and manner can inculcate a principle in a way which no elaboration of type or illustration can approach.

So far, then, as the systematic instruction is concerned, the training of our students in obstetrics could easily be put on a more satisfactory footing by increasing the number of necessary lectures. Perhaps sixty lectures would suffice.

The Need for Efficient Clinical Teaching.

Much more essential is the practical training which is necessary to enable the medical student to apply with success the results of his systematic knowledge. While the practical training has improved within recent years and exceeds the University requirement "to attend twelve cases of

child-birth," it is far from what it ought to be. The question then arises: How is this deficiency in practical training to be remedied?

It can be most efficiently done by a reorganization of our largest and most up-to-date obstetric hospital, the Royal Hospital for Women, and by making full use of the clinical material at our disposal. Our object should be to enable our students to obtain as sound a practical training in obstetrics in a lying-in institution as they do in practical surgery in the wards of a general hospital.

Better Equipment of Obstetric Hospitals.

This brings me to the need for the better equipment of our obstetric hospitals. However complete a lying-in hospital may appear on the day of its opening to the public, its completeness is short-lived. A modern obstetric hospital must be a thing of life and growth if it is to meet the needs of a rapidly increasing community. In this regard the recent movement of hospital standardization should play an active part. Hospital standardization would do more for obstetrics than any other organized effort could accomplish. It would furnish the highest degree of efficiency in caring for pregnant and parturient women and their offspring.

What, then, are the essentials of an up-to-date teaching obstetric hospital? As the time when obstetric cases occur cannot be regulated, we must arrange that the students are available when the labour is in progress. Obviously, the first necessity is a students' residence in the hospital grounds in telephonic communication with the labour ward. The only method by which the student can gain a clinical knowledge of the management of women in labour, normal and abnormal, is by residence in a lying-in hospital, when, not only is the labour seen, but the patient followed during convalescence. The course of instruction and residence, instead of three weeks, as at present, should be at least six weeks and a certificate of residence for that period with satisfactory attendance on at least twenty labours and practical demonstrations in the hospital, should replace the present requirement "to attend twelve cases of child-birth."

The next essential is a large pre-maternity department, both in- and out-patient. No recent development promises greater gains, both by the advancement of obstetric art and to the welfare of each individual patient and her infant. It gives full scope for the training of students while resident in hospital, in diagnosis by abdominal palpation, in pelvimetry, in the taking of blood pressure readings and it sheets home the cardinal importance of efficient pre-maternity examination in every single case. The intern pre-maternity department is a separate annexe to the maternity. Many of the patients are healthy country women admitted prior to delivery in the maternity hospital proper and such material is of great use for teaching purposes.

The addition of a labour ward to hold four to six patients, an instrumental delivery room, a fully equipped operating theatre and a septic block are obvious essentials.

Finally, an efficient staff to do the pathological

work is much to be desired. A pathological chemist would find abundant scope in cases of toxæmia, for it is only by modern bio-chemical methods of testing renal efficiency, an accurate judgement of the interference with the renal functions can be formed. This is a great field for research and it is to the pathological chemist we must look for advance. We need a well-equipped department, including pathological chemistry, under the direction of a skilled departmental head, who can give plenty of time to the work, with the necessary laboratory assistants. Here periodic demonstrations to the students could be given.

It is of great importance, too, to centralize the teaching. We must have ample clinical material and make the fullest use of that material. This can be best done by an all-round enlargement and bringing up-to-date the Royal Hospital for Women, for on the essentials named it is our best-equipped maternity institution. It has a students' residence in the grounds accommodating six, a pre-maternity department for thirty-five patients, seventy-three obstetrical and fifty-four gynaecological beds. The labour ward has six beds and there is a septic block accommodating twelve patients. The pathological department needs completely reorganizing. The hospital is central in position and has plenty of ground for expansion. Lastly, the responsible teacher of obstetrics in the University is *ipso facto* an honorary surgeon to the Hospital and as a teaching institution in the past it has been responsible for training the majority of students.

There is a movement on foot to duplicate the present Royal Hospital for Women, which it is to be hoped will be successful. It would appear, then, the essentials for an obstetric hospital affiliated with the University would be a hospital residence for twelve students, an increase of the number of pre-maternity beds to fifty, double the existing obstetric beds, two labour wards and instrumental delivery rooms, two operating theatres, an up-to-date septic block and an efficient pathological department, where the recent advances in pathological chemistry can be carried out.

The Clinical Teaching.

On the endowment of a chair the University could enter into an agreement with such a well-equipped central hospital to undertake the whole of the practical teaching of obstetrics. The entire honorary obstetric staff should help in the clinical teaching. Clinical lectures are not as advantageous, to my mind, as the method of teaching clinically any chosen subject by question and answer in an exhaustive manner. There should be a senior resident medical officer acting as obstetric tutor, young, keen and thoroughly experienced, who should be appointed by the Senate for a term of years. It would pay the University to send the appointee to the leading centres of obstetric teaching for a year for the advancement of the school. He should give up a certain defined amount of time daily to teaching in the labour and general wards and should instruct the students in residence to carry out, under his personal supervision, all obstetric operations on

the mannikin. The whole of the clinical teaching would, of course, be organized and under the control of the Professor when appointed.

There may be some who would suggest that such a scheme was entirely in the interests of the students. It must not be forgotten, however, that a teaching hospital is in itself a guarantee that the very best skill and the most considerate attention are given in exchange for the experience obtained.

The Need for Government Aid.

How are these much-needed reforms in the interests of mothers and infants, doctors and nurses to be effected? The Federal Government holds the key to the situation by a readjustment of the £5 maternity bonus. The £750,000 largely wasted annually in this manner, would, if distributed to the States *pro rata* to their population, cover the requirements of an ideal scheme for the most up-to-date hospital equipment. The Federal Government must recognize that the maternity bonus has to a large extent failed in its original purpose. The opportunity is now offered to deflect sufficient money for improved conditions in our lying-in hospitals. If one-tenth of the annual expenditure on the maternity bonus—£75,000—were given to the Royal Hospital for Women, a completely equipped hospital could be obtained by duplicating the present institution. Failing this, a yearly appeal to 5,000 women in affluent circumstances in this State to hand over their £5 maternity bonus in the cause of humanity would in three years reach the needed amount.

The State Government has done much for the hospital, but it ought to do a great deal more in the light of the important work done and the greatly increased cost of administration. When will our Governments realize that all expenditure on the furthering of health is the soundest possible investment for the money of the people?

We look, too, to the benevolence of generous donors, without which our University and our hospitals would not exist as they are to-day.

The Education of the Public.

An important duty of the medical profession is to scatter the seeds of enlightened obstetrics amongst the laity. This can be effected by each of our individual members, by various propaganda and it should be a function of the recently instituted "health week." As soon as the people understand the essential surgical nature of child-birth and the importance of proper care under suitable conditions and proper surroundings, they will begin to appreciate the great importance of good obstetrics.

Further, the public must be brought to the point when they will demand good services and provide ways and means for adequate compensation. Hitherto, these services have not been paid for adequately and our shortcomings, it is to be feared, are to some extent ascribable to that fact. The public has expected an expenditure of time and skill for fees that are by no means equivalent. The tendency of the profession has been to cut the loss by shortening the duration of the labour artificially. More time

devoted to fewer labours with better fees would mean better work with improved results, immediate and remote.

The public should be taught that the "confinement fee" no longer exists: it is replaced by the "obstetric fee," a composite fee which provides for proper ante-natal care, including a complete pre-maternity examination of the pelvis at the seventh or eighth month, efficient conduct of labour and the puerperium.

L'Envol.

I thank you for the patience with which you have listened to this somewhat discursive and desultory address. It has been my endeavour to rouse the spirit of lethargy which has retarded the advancement of obstetrics in the school to which I am privileged to belong.

We come and go. The old order changeth: each in turn plays his part on this mundane stage. The curtain falls: we sink behind the scenes and, drifting into the vast thoroughfare of the world outside, our voices are lost amid the tumult of the restless throng; or, as Lowell pithily expresses the sentiment:

Life is a leaf of paper white,
Whereon each of us may write
His word or two, and then comes night.

An Address.¹

By R. G. SCOTT, M.B., C.M. (EDIN.).

Retiring President of the Tasmanian Branch of the British Medical Association.

WE have come to the end of another year and it is for us now to look back and see what we have accomplished.

We have certainly had a more peaceful time, as, in our wisdom, I think, we have held our hand, allowing medico-political matters to take their course, in the hope that right must prevail and that the general hospitals would be put on a proper footing and be used for their legitimate objects: (i.) For the benefit of the sick poor, (ii.) as a training school for nurses, (iii.) as a place where the members of our profession can help the sick and gain experience (eventually for the public benefit). At present things are as they were, but there are signs that a change may come suddenly and unexpectedly. We have been fighting for a principle, the Ratten trouble only being a side issue. With the future interests of our profession and the real public good at heart, we could have acted in no other way than we have done. Whatever happens, we must recognize that the hospitals will never be staffed as old, as we believe the days of purely honorary service are past.

We have been ready at any time during the past year, as the Government know, to meet them with some such scheme as that agreed upon between Dr. Morris and a committee of our Council, but there has been no response so far.

Clinical Work at Our Meetings.

Dr. Terence Butler was appointed Clinical Secretary for the year and arranged work for most of the meetings. He has not been supported as he should have been and, until all the members take a more active part, the meetings cannot be as successful as we would wish them to be. It should be a privilege eagerly taken advantage of, to meet once a month to discuss the difficulties met with in practice. I hope that the ensuing year will see a great improvement in this matter to our mutual advantage.

I would like to take this opportunity to look back upon the last thirty years. In 1889 I took up the position of assistant house surgeon in the Hobart General Hospital, Dr. C. Payne being house surgeon at the time. Dr. Bright, Dr. Giblin, Dr. Gamaliel Butler and Dr. Wolfhagen were the honorary medical officers.

Development of Modern Medicine.

In those days appendicitis was practically unknown. I had seen one patient operated on for this condition in 1887 in Edinburgh, unsuccessfully, by the way. Visitors came from far and near to see the operation. The same may be said of extra-uterine gestation. Thomas Keith, Matthew Duncan and Lawson Tait were performing the operation of ovariectomy in the old country and thus facilitating the intra-peritoneal work of the future. Before then appendicitis was not differentiated from general peritonitis. Ovarian cysts were tapped and hæmatomata in the pouch of Douglas were expectantly treated. I can remember Dr. Bright telling me of the first attempt made here at the removal of an ovarian cyst by a surgeon newly arrived from the old country, who professed himself an expert. Evidently under the impression that the peritoneum was the cyst wall, he carefully separated it from the anterior abdominal wall, apparently without much aseptic preparation, as his gold signet rings on unprepared hands could be seen glistening through the tissues. The result was what might have been expected.

Before and at this time it was customary to operate in old clothes, the older and more encrusted with blood the more workmanlike they were supposed to be. Old frock coats were most in favour and so stiff were they with blood that most of them could stand by themselves.

Early in the 'nineties more aseptic measures were introduced and the whole technique of operating was improved. The new methods were greatly facilitated by the Solomon bequest, which enabled an up-to-date theatre to be erected and it was not long before intra-abdominal work was being freely and successfully done. About this time assistant honorary medical officers were appointed, Dr. G. Sprott and myself. Dr. A. H. Clarke, Dr. W. W. Giblin and Dr. Lines followed us and eventually in turn we all became full honorary medical officers. Before the operating theatre was built, operations were performed in the small ward off the accident ward. I remember Dr. Wolfhagen performing an urgent amputation at the shoulder joint by candle and gas light there and Dr. Giblin and Dr. Gamaliel Butler

¹ Delivered at the Annual Meeting of the Tasmanian Branch of the British Medical Association on February 15, 1922.

operating for a strangulated hernia almost in the dark.

Typhoid fever was rife and the wards for both male and female patients were crowded during the epidemic. With deep drainage, all this was altered and now enteric fever has become a comparatively rare condition. Those of us who held honorary positions on the staff, took week about on duty for admissions to the hospital and visited the hospital every day, operating, as a rule, two afternoons every week. Many urgent operations were performed at night.

Obstetric Practice.

Similar conditions obtained in obstetric work as in operative work. All patients were treated in their own homes. There were no maternity homes and no trained nurses. "Mother Gamp" was much in evidence. The results were often appalling; septic conditions were common and the life of the obstetrician was anything but an enviable one. With the advent of the Alexandra Hospital in Hobart and the Victoria Hospital in Launceston, where much the same conditions existed, things improved and a constant succession of trained nurses was provided, the majority with the Australasian Trained Nurses' Association certificate. A Branch of the Australasian Trained Nurses' Association was then established in Hobart. About the same time a *Midwifery Act* was passed, weeding out most of the untrained nurses and making it compulsory to pass a Government examination after 1907.

Everything obstetrical has much improved and now splendid results are obtained in the hospitals and outside them with the help of the trained nurses provided. Of course, we are still far from perfection and there are many improvements foreshadowed, chief among them being more pre-natal care of the patient with abdominal examination and measurement of the pelvic diameter, more regular and frequent examination of the urine and better dietetic measures.

At the time of confinement, less meddlesome midwifery and a more intelligent use of the forceps have been introduced.

Dr. T. G. Wilson, of Adelaide, at the Brisbane Congress, quoted statistics in Liverpool for 1918, which showed only 5.48% of patients attended by medical men and yet there was relatively more sepsis in the 5% than in the 94% attended by midwives. This is only an isolated instance, I hope, but still the fact is that there is much more morbidity than there should be and that more care and better methods are still called for.

Eclampsia is much too prevalent and with more pre-natal care many cases will be avoided. When albuminuria associated with diminished urine and high blood pressure does not clear up under treatment, the induction of labour, brought on at the proper time, will save many lives. The same applies to *placenta prævia*, contracted pelvis, post-maturity of the infant and also to cardiac and other constitutional disease of the mother. With proper indications Cæsarean section, carried out before interference has increased the dangers of operation, will mark another important advance.

Endocrinology.

The future is full of promise, with its serum and vaccine therapy, with the further knowledge of the vitamins and with the advance in our knowledge of the endocrine glands and the necessity of keeping their secretions well balanced. Those of us who have witnessed the dramatic recovery of a *cachexia strumipriva* after the administration of thyroid gland substances, cannot doubt the efficacy of the treatment and the promise that a further knowledge holds out to us.

Bandler, in his lately published book, states that for years 90% of his medication has consisted of endocrine extracts. He also states that, to be intelligently used, they must at first be prescribed separately, as otherwise we will be acting blindly and will get confusion.

The cessation of the menstrual flow during pregnancy and the cause of the onset of labour are among the fascinating problems about to be solved by knowledge of the endocrine secretions and their inter-relations.

Improved methods of research and the establishment of bacteriological laboratories in every large centre, as foreshadowed by Dr. Cumpston, will help us in our diagnosis and make plain that which was obscure before. At the same time, we must not lose sight of our old clinical methods. Let us endeavour to cultivate a clear vision, good conscience and the strength and determination to become efficient. Then will come the peace that passeth all understanding.

Professional Matters.

I do not think that our annual dinner should be allowed to lapse, as it tends to promote good fellowship and gives us a more intimate knowledge of each other. I would like to-night to emphasize the necessity of not neglecting the many courtesies that go to the making of medical etiquette. In our dealings with each other we cannot be too punctilious and that, combined with a honest professional morality, will carry us far. "Do unto others as you would wish them to do unto you" will do away with much unnecessary professional jealousy and will enable us to carry out our daily work in all friendship and harmony.

The public are only too ready to take advantage of any disputes amongst ourselves. Therefore, it is our duty to show a united front. In this way we will gain and keep the respect of the people and increase the dignity of our profession. Let us, each one, work for the common good and endeavour to leave the profession when our time comes a little better or at least no worse for the fact that we have been members of it.

Excuse all this and take it from one who is most conscious of his many faults, but who wishes you all the best that can happen to you!

I have to congratulate our new President, Dr. Hogg, and to introduce him to the chair, which he has so successfully filled previously, with the hope that the future year will be full of prosperity for him and the Tasmanian Branch of the British Medical Association under his care.

THE PREVENTION OF TUBERCULOSIS.¹

By ROY C. MERRYWEATHER, M.R.C.S., L.R.C.P.,
Honorary Physician, Perth Public Hospital.

THE question of the prevention of tuberculosis is so inextricably bound up with the question of early recognition and rational treatment that I propose in the short time that is at my disposal to endeavour to direct your attention to the subject proper, in so far as it is influenced by these factors. I shall confine myself to the disease as it affects the pleuræ and lungs.

Tuberculosis Affecting the Pleuræ.

It is now, I believe, well recognized that by far the greater number of sero-fibrinous pleurisies are in reality tuberculous in nature, though certainly there may be many exceptions. We have all no doubt realized that when the after history of these cases is followed up, we have been able to trace the development of the same disease in the lungs. Moreover, it has been demonstrated by special methods that the fluid contains tubercle bacilli. Furthermore, inoculation experiments with guinea-pigs, provided that large enough quantities of fluid are injected, *e.g.*, fifteen cubic centimetres to fifty cubic centimetres, produces undoubted tuberculosis in from 50% to 85% of these animals. I mention this in particular, since I think it is always necessary to treat a patient suffering from pleurisy with effusion in practically the same manner in which those suffering from pulmonary tuberculosis should be treated. This treatment will be described later on.

It is well to remember in the diagnosis of this condition that the fluid is by no means devoid of sound-conducting power. The presence therefore of breath sounds on auscultation over an area in which the fluid is suspected, need not deter us from a positive diagnosis if other indications point to effusion. There is, however, one sign almost pathognomonic of effusion which I have rarely found fail me, *i.e.*, ægophony. In these cases the whispered voice will be very distinctly conducted through the fluid.

The question as to whether dry pleurisy, without previous disease of the lung, is due to the tubercle bacillus is still a debatable point. I cannot help feeling that a tuberculous dry pleurisy is not so rare as is commonly stated and for this reason I think that the treatment of this condition should always be conducted on the presumption that it is tuberculous in origin, so that its potentialities for further mischief may be effectively checked.

The early diagnosis of pulmonary tuberculosis is very essential; only on the basis of the correct diagnosis in the early stage can the complete arrest or, indeed, cure be brought about. Of all the definite signs of pulmonary tuberculosis, I think I am not too dogmatic in stating that hæmoptysis, provided that the blood has been proved not to come from the upper air passages, should be regarded as an almost positive proof of the disease.

Alas, how many cases of hæmoptysis have been

treated lightly by medical men in the past, when often the golden opportunity is lost of immediately placing the patient under treatment! I consider the patient who is the unfortunate possessor of an invasion from the tubercle bacillus, to be singularly fortunate should the first sign be hæmoptysis. A chronic cough, even if accompanied by wasting, is often neglected, whereas the presence of blood which has been coughed up almost invariably frightens the patient into consulting his medical man, who should never disregard so timely a warning, even though the physical signs be wanting. The sputum, if examined at the time of hæmorrhage, may fail to reveal the presence of the specific organism. On subsequent examination, however, when the hæmorrhage has subsided, the organism may frequently be discovered. Too many medical men are apt to draw hasty conclusions from a single resultless examination of the sputum. I should like to emphasize the necessity of repeated and frequent examinations in all cases where there is reason to suspect tuberculosis. In some of my cases the organism has been found only on the third or fourth examination. How many cases, also, of so-called pneumonic influenza were in reality cases of tuberculosis of the lungs, cases which should, perhaps, have been diagnosed correctly, had the sputum been examined, not once, but many times? The physical signs of chronic pulmonary tuberculosis are so well known that I will not weary you with them. I would, however, remind you of the predilection of the tubercle bacillus for those surfaces of the lung which are in apposition and in this regard would emphasize the following points:

- (i.) Never neglect auscultatory examination on either side of the sternum.
- (ii.) Never neglect examination of the axillæ, especially at their apices.
- (iii.) Should you fail to detect any signs of disease, even at the above-named sites, do not forget to make the patient cough and immediately to take a deep breath. Post-tussive crepitations are frequently elicited in this way.

Treatment.

I am one of those who have a profound belief in the efficacy of sanatorium treatment, provided that it is properly carried out. I had the great advantage of being Assistant Medical Superintendent at the Brompton Hospital Sanatorium at Frimley, in Surrey, England. In 1905 I was asked to assist Dr. Marcus Paterson, who was then Resident Medical Officer at the Brompton Hospital, in organizing the new Sanatorium at Frimley. It was during that year that definite graduated labour was started, perhaps as a sequence to Walther's experience at Nordrach, in view of the excellent results that had been obtained by graduated walking exercise. I can well remember with what fear and trepidation we started the patients on this graduated labour. Walking exercise was first prescribed for all patients able to indulge in it, starting with half a mile a day and gradually increasing week by week, until they had reached six miles a day. The first grade of labour consisted in carrying small baskets containing various materials about fifty yards. The weight

¹ Read at a meeting of the Victorian Branch of the British Medical Association and of the Section of Preventive Medicine on September 7, 1921 (see THE MEDICAL JOURNAL OF AUSTRALIA, January 14, 1922).

was then increased, as well as the distance. Eventually, from such small beginnings, through many and various stages, *e.g.*, mowing grass, small shovel work, the penultimate stage of five hours' hard navy work a day was carried out. After they had been successful in going through all the grades without signs of retrogression or stagnation, they were put out to work at their various trades for six weeks. This was done to accustom the muscles used in their particular trade to the work they would be required to perform.

The patients with few exceptions entered heartily into this work, realizing that it was for their benefit and that they were in fact doing useful work for the sanatorium, which was their temporary home. Had they been put to useless work, boredom and depression would have resulted. I understand that this treatment is still being maintained. As to the results of the treatment, I can give you only the following statistics:

During 1908 242 patients were discharged. One hundred and forty-six patients were at their work in February, 1911. Nineteen were not at work. Forty-four did not report and thirty-one had died.

Therefore, 60.3% were able to earn their own living after three years of work since their discharge from the Sanatorium. I need not stress the fact that for sanatorium treatment each patient should be carefully selected, not only from a physical examination point, but also from the point of view of his individuality. "A fool rarely recovers from tuberculosis of the lungs."

Now what is the best method of dealing with patients suffering from pulmonary tuberculosis in our States? They come under two headings: (i.) Those that can afford private treatment. (ii.) Those that cannot.

For the former I feel certain that some institutional treatment is necessary, particularly as a preliminary to subsequent treatment, provided it is conducted on sound lines. Rest in bed is essential for at least three weeks, during which time much accurate information, such as the variations of temperature, suitable diet, etc., can be gained from the reports of a reliable nursing staff. It is sometimes astonishing to note the improvement that occurs, even after a short, complete rest. The patients should not be allowed to sit up in bed nor to get out of bed, even for the relief of the bowels. In other words, they should be treated exactly in the same manner as they would be treated if they had enteric fever, except they should be given very liberal diet, more particularly in the direction of underdone animal food. Milk, the one-time favourable diet for such cases, is, I venture to say, much over-rated. It appears to do little more than fill the stomach and so incapacitate it from ingesting other and more profitable articles of food. Should the temperature have been normal from ten to fourteen days, the patient should be allowed to sit up in bed from one to three hours each day, this length of time being increased if there is no rise in temperature consequent upon it. At the end of the third week they may be allowed out of bed and so until they are able to walk at least six miles a day with-

out harm. The minimum length of time spent at an institution should be three months. They may then be allowed to go to their homes and continue the graduated exercise or labour until such time as they are well and fit to resume their work.

The result from such treatment has so far been very gratifying. This institutional treatment for private patients, if properly carried out, also serves naturally as an educational factor in the prevention of the disease. The patients, after leaving an institution, should be recommended to report to their medical man at monthly intervals at least. I have omitted to refer to the question of weight, which, in addition to the temperature, is also taken as an indication of the patient's progression.

For those whose means do not permit of treatment such as I have indicated in private institutions, the State sanatorium should offer similar opportunities. Unfortunately, one frequently finds that a public sanatorium, far from being what its name implies, is in fact the last refuge of those who are long past the stage of recovery. The presence of such patients in a sanatorium militates against the success which can be attained in a well-regulated private institution. The psychological effect alone acts as a deterrent towards improvement in those who otherwise might be expected to obtain relief through the advantage of institutional treatment.

One essential for the success of any sanatorium treatment is a careful selection of all patients recommended for admission. Those who are unlikely to benefit by such treatment, that is, those who are past the stage of recovery, should be sent to a home provided by the State, where everything possible should be done to relieve them during the last days of their life. The selection of patients might be well relegated to an advisory board consisting of two or three with special knowledge of the disease. If this were done with all public sanatoria, a great benefit to the public health would surely follow. The selection of patients for admission and the banning of persons in an incurable condition would result in enjoyment by the public sanatorium of a greater measure of popularity than now exists.

The segregation of patients with advanced disease in homes or colonies under conditions made as favourable as possible would help to remove from the community a prolific source of infection, while their absence from the sanatorium would do away with that morbid influence which so often deters a person in the early stages from seeking admission.

Apart from the selection of patients, there is one other point in connexion with sanatorium treatment which must not be overlooked if success is to be attained. Given the right type of patient, one must have the right type of man to take charge of him. The medical superintendent of such an institution is an autocrat; his word is law; and upon his personality depends the fate of many of his patients. It is not enough that his knowledge may be profound. He must have enthusiasm and, moreover, he must have the gift of infusing such enthusiasm into his patients, who should be constantly under his supervision, so that they take a lively interest in their treatment. Too many private sanatoria are

just hotels, where patients are well housed and well fed, but where treatment is practically non-existent. In other words, in choosing a sanatorium for a patient, one should first of all know the character of the medical superintendent, as well as the locality, etc., of the institution itself.

Before leaving the question of treatment, I would like to refer briefly to another point.

In 1913, in collaboration with my friend, Dr. Shearman, of the Central Board of Health, Perth, I decided to try the effect of autogenous vaccine therapy, with the object of immunizing the patient against the mixed infection which invariably occurs with chronic pulmonary tuberculosis. In the first series in which this was tried, the vaccine was prepared from the organisms found in the sputum and known to have a pathogenic existence. After culturing many specimens, it was noticed that the organism that recurred with greatest frequency was the streptococcus. This organism is now regarded by Dr. Shearman as the chief cause of secondary mischief in tuberculous affections of the lung.

Many patients have shown remarkable improvement under vaccine therapy in which an autogenous streptococcal vaccine has been employed. In view of the frequency with which the streptococcus is found in secretions from the respiratory mucous membrane in apparently normal people, Dr. Shearman has suggested that its pathogenicity in tuberculous individuals may be due to a symbiotic relationship between this organism and the specific bacillus in pulmonary tuberculosis. Whether this is so or not, the fact remains that by actively immunizing the patient against his streptococcal infection by means of autogenous vaccine a marked improvement follows in his tuberculous condition.

Infection.

There can be no doubt that patients may be further infected or re-infected from themselves or from other people. Secondly, no one can become tuberculous except by the invasion of the tubercle bacillus from pre-existing disease, either in man or animals. Thirdly, the direct transmission from parent to child must be so rare that there is no need to lay stress on it.

The tubercle bacillus seems to vary in virulence. Those found in glands are apparently less virulent than those in the sputum. It has been calculated that a single individual may expectorate many million bacilli in twenty-four hours and it has been conclusively proved that the dust around a tuberculous patient's bed contains the tubercle bacillus in abundance for at least six weeks after death.

Infection from Food.

This has been always hotly debated, though I think undoubtedly that the balance of opinion is greatly in favour of its probability. In 1901 Koch stated that such infection was not proven. He failed to infect cattle with tubercle bacilli from human sources and concluded that human tuberculosis was different from the bovine variety. He also stated his opinion that primary tuberculosis of the intestines of children was very rare. It has been pointed out, on the other hand, that human and

bovine tubercle bacilli are identical in shape and can be grown in exactly the same manner. It has also been demonstrated that tuberculin produces the same reaction in tuberculous cattle, whether human or bovine bacilli have been employed in its preparation. Again, it has been proved that the tubercle bacillus may pass through mucous membrane without leaving traces. One of the remarkable proofs that human beings can be infected from animals is the case of a veterinary surgeon who inoculated his thumb while dissecting a tuberculous cow. Six months later tuberculosis of the skin appeared in the scar and pulmonary tuberculosis developed later. The patient died.

It seems much safer, therefore, for us to take every precaution and warn the public against eating contaminated food. I heard it stated by a well-known London physician during a discussion on vitamins last year at Cambridge that we were overdoing the sterilization of food-stuffs for children and that the less the food was sterilized and the more the child received the foods of the earth in the same manner as the Almighty had given it to us, the healthier the child would become and the stronger the race. Recently in the old country it has been advocated, even by tuberculosis experts, that for children to receive a mild infection of tuberculosis, even from food-stuffs, does not harm them to the extent that was thought hitherto; rather does it make them more immune to subsequent and even more severe invasions.

As to the advice which should be given to discharged patients, I mean those in whom the disease has become arrested, it is certainly unwise for practitioners to advise all and sundry that they must get a light job in the country in the open air, for the simple reason that a good tradesman can earn a good living wage at his own particular trade, even though it is indoors, and so make satisfactory provision for his well-being and at the same time keep well. A skilled tradesman who can earn good wages at his own particular trade, may not be able to support himself, say, as a farm hand or a gardener. As Paterson says: "He must be guided by the relative economic value of his work and must take into consideration the nature of his environment when off duty."

In conclusion, I must thank you for the patient hearing that you have given me. If I seem to have wandered away from the title of the subject, "The Prevention of Tuberculosis," I submit that the surest way of effecting prevention is by the early recognition of the disease, its institutional treatment and the education afforded by such treatment. As Sir Clifford Allbutt recently stated at the Annual Meeting of the British Medical Association at Newcastle-on-Tyne: "In spite of all the gibes that have been directed against sanatoria, a fall of something like 15% in the tuberculosis rate had been affected. Although the effort has been as imperfect as efforts on a large scale must be, the incidence of that awful plague has been substantially diminished. With the establishment of tuberculosis colonies, I hope and believe that there will be another large fall in the course of the next ten years."

ROUTINE OF A SYPHILIS CLINIC.¹

By W. J. BEVERIDGE, M.D. (BRUN.), L. & L.M.R.C.P. (IREL.),
L. & L.M.C.S. (IREL.),
North Perth.

IN these days when patients suffering from syphilis are usually submitted to intensive arsenical treatment, accurate diagnosis should be aimed at as soon as the patient comes under observation and before any specific treatment be given. This cannot be too strongly insisted upon, as we all know how one or two intervenous injections of "606" may clear up all signs and symptoms of the disease, rendering a positive diagnosis impossible.

These patients often return after long periods, suffering from late or postponed secondary syphilitic symptoms, neuro-syphilis being a frequent occurrence.

Intensive treatment has its own dangers, immediate and remote. In its early days there were many deaths due to the treatment, deaths due to arsenical poisoning and deaths due to acute syphilitic toxæmia brought about by the killing of great numbers of spirochaetes and the sudden liberation of large quantities of syphilitic "toxin."

With greater care in treatment there are now few deaths from this cause.

During the past few years neuro-syphilis has become very common and is particularly so amongst patients giving a history of early arsenical treatment.

An accurate diagnosis of syphilis in any of its stages is not sufficient information on which to start treating a person suffering from that disease. A careful estimate of his general health should be made, especial attention being paid to the kidney function, the blood pressure and the condition of the nervous system. Only then can the surgeon decide on the line of treatment to be adopted.

I propose to-night to describe shortly the routine of examination and treatment of cases of syphilis at a military hospital (No. 39 General Hospital, British Expeditionary Force).

The hospital was a double general hospital, divided into three sections, dermatological, syphilitic and gonorrhœal.

The syphilitic section was in charge of Major Arthur White, R.A.M.C., who was assisted by three medical officers, each of whom acted as house surgeon for his sub-section. Each sub-section had its own receiving room, with staff of orderlies and clerks.

On admission the patient was taken to a warm, well-lit room and his name, etc., entered on his card as follows: (i.) History of previous venereal disease, if any, was noted. (ii.) He was questioned regarding the cause of "going sick." (iii.) If a venereal sore was present, the date of its appearance was noted. (iv.) Previous treatment, if any, was entered.

He was then stripped and weighed and was placed in a good light before the medical officer, who exam-

ined him and dictated his notes to a clerk. The routine was as follows:

(i.) An examination was made to ascertain if a primary sore or scar was present. The entry included the situation of the sore or scar, the history of the infection and the character of the sore or scar. The character was described in accordance with Major White's classification, which I will detail later.

(ii.) The mucous membranes were inspected. For this purpose the patient was required to evert his upper and lower lips and to protrude his tongue. The tonsils and fauces were also inspected.

(iii.) The inguinal, axillary, epitrochlear and cervical glands were palpated in this order.

(iv.) The skin was inspected to determine whether or not any lesion was present. The types of dermatitis were specified as roseola, macular, papular, scaly, pustular, rupial, scabies, seborrhœa.

(v.) The anal region was always inspected for the detection of condyloma, ordinary or hypertrophic. The patient turned his back to the light, bent from the hips and with his hands separated the buttocks.

(vi.) The eyes were inspected, the condition of the pupils noted and it was noted if Romberg's sign was present.

(vii.) The knee jerks and other reflexes were tested.

(viii.) Other signs of syphilis, such as periosteal nodes, gummata, ulcerations, etc., were sought for.

(ix.) It was noted if any complications or other diseases, such as scabies or gonorrhœa, were present.

(x.) An examination of the urine was carried out in every case. The heart and lungs were examined.

Any urgent treatment was then given. This examination did not take more than a few minutes. The clerks were well up in their work and soon learned the technical terms. The patients were well instructed and knew what they had to do. In describing the skin condition the word syphilis or syphiloderma was not used.

Patients requiring dental treatment were referred to the dental officers.

On the following morning the medical officer paraded before Major White all new patients and all others due for review or treatment. The new patients were called first. These parades were at 9 a.m. daily and were usually attended by visiting medical officers from our own and other hospitals. Each patient entering the room dropped his shirt and tunic on the floor, stepped in front of the window and dropped his breeches to his ankles. His card was read by Major White, who would demonstrate any point of interest or diagnostic importance.

A diagnosis was entered on his card for the first time and treatment was ordered. A Wassermann test was ordered if necessary. In the case of a doubtful venereal sore, a diagnosis was always aimed at. In the appropriate segment of the card the diagnosis was entered, either as (i.) clinical soft sore or as (ii.) clinical primary syphilis. The patient was then referred for microscopical and serological examination. In this hospital, as in other British hospitals which were used as training

¹ Read at a meeting of the Western Australian Branch on November 16, 1921.

centres for venereal disease work, great efforts were made to train in clinical observation.

All cases were reviewed at fixed periods or at any other time if the medical officer considered it advisable. Severe reactions, anorexia, loss of weight, albuminuria were constantly watched for; every patient was weighed and his urine was tested before each injection.

In the afternoon the same lot of patients paraded for treatment, those for intravenous injections being taken first.

Intravenous Injection of "606."

The gravity apparatus was used, Major White and the medical officer on duty sharing the work. Six tables were placed parallel to each other down the centre of the room. Extended arm rests were used. The medical officers were behind the heads of the tables with orderlies, who prepared the solutions, needles, etc.. The solution used was 0.1 gramme in 30 cubic centimetres of saline solution.

The patients entered by one door and left by a door on the other side of the room. They were placed in position and prepared by another set of orderlies. This is a much better plan than that which is adopted at Park House. When the patients receiving injections of salvarsan had been disposed of, another set of patients arrived for intra-muscular injections of mercury and of "914."

A long table was placed across the end of a big room; at each end was a medical officer; between them were the orderlies, who sterilized the needles and filled the syringes. Two more orderlies attended to the patients, each placing his man in position in front of the medical officer. Injections were made into the buttock. Relaxation of the gluteal muscles was obtained by placing a twenty centimetre footstool under the foot on the side for operation. Tincture of iodine was applied by the orderly. The mercury injection was then given. If it were intended that the patient should receive an intra-muscular injection of "914," it was immediately given in the same buttock. The medical officer endeavoured to place the mercury close to the iliac bone and the "914" into muscle substance or into the intra-muscular cellular tissue. The orderly massaged the buttocks for a few moments and the patient moved on. Other orderlies filled in details on the men's cards.

The men came in in pairs at one side of the room and passed round the table and out. The double injection was given in less than five minutes. Whilst in the line going up the patients saw on the walls large pictures showing the position in which they were required to stand.

The injection of "914" was given in glucose solution. The dose was dissolved in 0.9 to 1.2 cubic centimetres. The solution used was as follows: Guaiacol, 1; glucose (liquid), 50; water to 100.

When the double injection was given, pain was at times severe and in some cases there was considerable cellulitis; abscess formation from tissue necrosis occurred in a few instances.

Patients undergoing treatment were subject to (i.) an immediate vaso-motor disturbance, commonly

called "nitroid" crisis. The patient felt faint, then flushed and suffocating; he usually vomited. Relief was obtained by a hypodermic injection of 1.2 to 1.8 cubic centimetres of a 1% adrenalin solution.

The measures of prophylaxis employed were rest, abstinence from food for two hours before the injections and a preliminary injection of 0.6 to 0.9 cubic centimetre of adrenalin solution.

The other incidents of treatment were (ii.) rigors, vomiting, cramps or diarrhoea occurring after a few hours; (iii.) urticaria, herpes zoster; (iv.) jaundice; (v.) mercurial stomatitis; (vi.) anorexia and loss of weight; (vii.) arsenical dermatitis, starting as an erythema and in severe cases becoming vesicular. Pustulation frequently caused these eruptions to become very serious. Pulmonary congestion was frequently present. (viii.) Severe cerebral symptoms, starting some hours or a day after injection. These were treated by (a) purgation, (b) injection of adrenalin and (c) in patients showing much cyanosis or coma, by venesection.

The occurrence of any of the above showed that the patient was intolerant to arsenic and indicated that the treatment should be modified or suspended. Arsenical dermatitis sometimes started after a course of treatment had been concluded.

Classification of Venereal Sores.

The following classification of venereal sore was adopted by Major White:

Primary Syphilitic Sores.

Among 9,000 infections analysed, there were 1,718 multiple sores. The types were as follows: (i.) Hunterian chancre, 13.45%; (ii.) syphilitic abrasive sore on the *glans penis*, 2.96%; (iii.) granulating syphilitic sore, 21.21%; (iv.) papular syphilitic sore, 0.79%; (v.) papulo-erosive sore, 29.31%; (vi.) papulo-ulcerative (infected) sore, 2.28%; (vii.) phagedænic sore, 0.79%.

Of these, the first, fourth and fifth types are well described in most text-books; the sixth and seventh are simply due to secondary infection. The second type, syphilitic abrasive sore, is small, easily overlooked, heals readily and its importance is often not noted. If it does not heal easily, it will develop the characteristics of the fifth or sixth type and may become a typical Hunterian chancre.

The third type, the granulating syphilitic sore, is the commonest type of primary sore on the skin. It is frequently on the shaft of the penis. Its size varies from that of a three-penny piece to that of a half-a-crown. Its shape is circular or oval. In appearance it is smooth, red, raw and granulating. Its edges are shelved like bevelled glass. The sore is raised above the surrounding skin. Induration is slight, but definite. When first seen it may have a pustular scab due to secondary infection. This is a common primary syphilitic sore, yet it is frequently not recognized as such.

Venereal sores may occur in any of the following situations: (i.) The *glans penis*, (ii.) the mucous membrane of the prepuce, (iii.) the skin of the prepuce, (iv.) the corona, (v.) the coronal sulcus, (vi.) the meatus, (vii.) the urethra, (viii.) the shaft of

the penis, (*ix.*) the scrotum, (*x.*) some extra-genital position. These situations are given, not in the order of their relative frequency of infection, but in the order in which systematic search is made for signs of infection.

Extra-Genital Chancres.

There were one hundred and thirty-one extra-genital chancres reported, distributed as follows: The lip, seventy-eight; the tongue, eleven; the finger, eleven; the chin, nine; the tonsil, three; other situations, nineteen. They were usually single. Chancres of the lip, tongue, tonsil and finger were usually papulo-erosive or papulo-ulcerative. Of those on the skin, the primary granulating type of sore was the commonest.

Concealed Syphilitic Sores.

Concealed syphilitic sores were found in 26.3% of the patients examined. Urethral syphilitic sores occurred in 0.08% of the patients.

It is probable that urethral syphilitic sores are more common than this figure would indicate. A urethral syphilitic sore may be easily overlooked or mistaken for non-specific peri-urethritis or an enlarged urethral gland.

A venereal sore beneath a phymosed prepuce is common (26.3%) and, unfortunately, they are not easy to differentiate. The differential diagnosis is rendered more difficult by frequent double infection or by a co-existing gonorrhoea. There are some characteristics of these sores which assist in making a diagnosis.

In endeavouring to ascertain the existence of concealed sore the following points are taken into consideration:

(i.) The history and time of infection. If over two or three weeks a syphilitic sore is probably present.

(ii.) The condition of the prepuce. If a syphilitic sore be present, there is a non-inflammatory oedema with a livid dark colour. In the case of a soft sore there is redness and inflammation.

(iii.) The presence or absence of a discharge. In the case of a syphilitic sore, it is slight and serous. In the case of a soft sore, it is purulent.

(iv.) The existence of adenopathy. With a syphilitic sore the inguinal glands are hard and shotty, discrete but not painful. With a soft sore the glands are enlarged, soft and painful on palpation. There is sometimes peri-adenitis, abscess formation and bubo.

(v.) On palpation it is found that the syphilitic sore is indurated, but not tender. The soft sore is painful to the touch.

(vi.) Gland puncture for serological examination with dark ground illumination is usually used.

(vii.) The Wassermann test may be carried out after twenty days from the onset of the sore.

Procedure.

These patients were fomented and syringed with saline solution. The sore was massaged and squeezed and an endeavour made with a pipette or a platinum loop to obtain some serum for exam-

ination for *Spirochæta pallida*. Circumcision in these cases was not favoured as a routine.

If the case was classed as syphilis, operation was put off till twenty-four hours after an injection of "606." Local anæsthesia was usually employed.

Where there was marked inflammation of the prepuce, the usual procedure was to slit it up by two lateral incisions, the single dorsal incision having frequently proved unsatisfactory.

Neuro-syphilis was not common in the British Expeditionary Force.

Late or deferred secondary syphilis was frequently seen.

Neuro-syphilis was treated with "606," followed by mercurial injections. The starting doses of "606" were always small. The results were good as regards the symptoms, but the Wassermann reaction frequently persisted.

Tertiary syphilitic symptoms were treated usually with the old-fashioned mercury and iodide of potash. When the symptoms were relieved, the man was returned to duty or recommended for discharge as medically unfit.

The Royal Army Medical Corps for very many years has been carrying on careful observations on the treatment of syphilis. The elaborate notes taken of cases were made use of when the courses of treatment were being planned. The syphilis case sheet contains a very complete record. It was written up from the man's small card.

In the German Army they went one better. A German soldier suffering from syphilis, when returned to duty, carried a small card with him, setting out his treatment up to date. We found these very useful.

In the Royal Army Medical Corps special courses of instruction in venereal diseases and their treatment are held regularly and officers passing such courses will be eligible for "specialist pay" when placed in charge of venereal diseases hospitals. All work of an operative nature is carried out by officers. No orderlies are permitted to give injections or to take blood samples for Wassermann tests or serum for microscopic examination.

All anti-syphilitic treatment was ordered by the specialist officer in charge, Major White, who saw every patient. He was enabled to do this by the splendid organization existing and by the system of working alternate days with his assistant medical officers.

Interesting and instructive lesions were frequently photographed. Results of much of this work appears in Harrison's work on "Venereal Diseases" and also in "The Atlas of Primary and Cutaneous Lesions of Syphilis," compiled by Major White and Captain Brown from the cases seen in No. 39 General Hospital.

The present methods of treatment of syphilis are being subjected to severe criticism. A few years ago deaths were not infrequent amongst those undergoing intensive treatment. The dosage used is now reduced and with the greater care in administration deaths have become very rare.

Really intensive treatment, aiming at a rapid and total extermination of the *Spirochæta pallida*, is

only attempted now in the early-primary stage. In the later stages we must place our hopes on prolonged treatment, in which mercury is regaining the premier place.

During the late war, when large numbers of syphilitics could be kept under military control for observation, we were enabled to study the immediate effects of the treatment carried out. During the next few years it will be interesting to see what will be the later effects of the arsenical treatment of these large numbers of white troops. Frazer and Duncan, in an interesting article in *The British Journal of Dermatology and Syphilis* (July, August and September, 1921) refer to a great increase in neuro-syphilis amongst South African natives, the neuro-syphilis occurring amongst those who had been under intensive arsenical treatment. Before the introduction of this treatment, neuro-syphilis was almost unknown amongst the natives, though other forms of syphilis, both secondary and tertiary, were not uncommon.

It is quite possible we may find many neuro-recurrences amongst returned soldier syphilitics in Australia. That good results can be obtained in the treatment of such cases is well known, but the treatment must be thorough. The condition of the patient is dangerous and the treatment itself is not devoid of dangers, both immediate and remote.

Many syphilitics are like late consumptives, in that they have lost their wage-earning capacity and are not able to pay for expensive treatment. They cannot afford to lie up or to get proper nourishment. Free treatment for syphilis is now being given in many States and the system of indiscriminate treatment has been the subject of much criticism. However much our opinions may differ on the subject of free treatment, we must all agree that any treatment supplied should be both safe and efficient. Annual reports of large numbers of patients attending venereal disease clinics may indicate that the clinics are popular, but they do not guarantee efficiency. We read and hear much about the venereal disease problem and about schemes for prevention and for cure, yet we still see venereal disease clinics poorly equipped and financially starved.

Is it too much to ask that the civilian syphilitic should be given as good treatment in peace time as the soldier received in war time?

Reports of Cases.

A CASE OF XANTHOMA DIABETICORUM.

By G. R. HAMILTON, M.B., CH.M.,

Honorary Assistant Dermatologist, Sydney Hospital;
Honorary Dermatologist, Royal North Shore
Hospital of Sydney.

ALTHOUGH *xanthoma diabeticorum* is a rare cutaneous disease, yet it is not particularly for that reason that I am recording this case, but on account of the condition having been diagnosed as small-pox.

The patient, R.J., aged forty-seven years, a wharf-labourer, was sent to the Board of Health as suspected of suffering from small-pox; from there he was sent to my Skin Clinic at the Sydney Hospital.

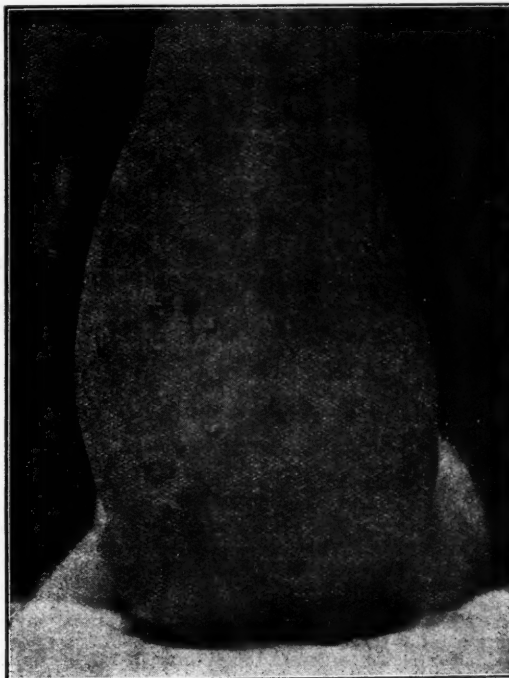


FIGURE I.

On examination the patient was found to be of good general healthy appearance, of the stout and florid type. He exhibited multiple papules on the extensor surfaces of his elbows, thighs and knees. The eruption had occurred quite suddenly, the first papule appearing on the left knee, then next day one on the left elbow and in a few days many came out on his elbows, knees and thighs on both sides. The only symptom the patient had was that the papules

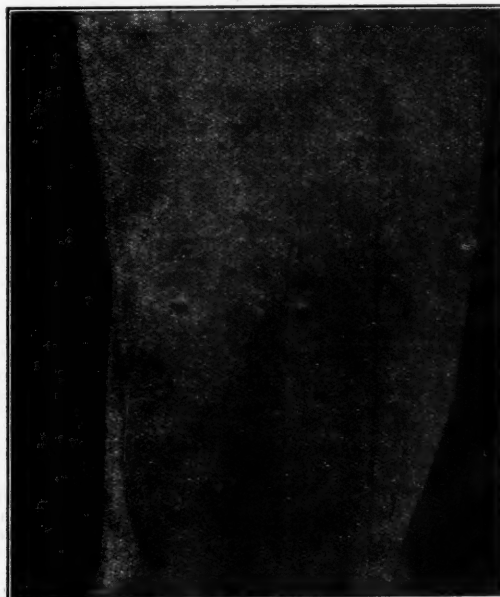


FIGURE II.

itched slightly when they were appearing. The papules were firm, solid and discrete, of a pink coral appearance with a slightly yellow top and varied in size from that of a pin's head to 0.8 centimetre in diameter.

A section of one of the older papules was examined by Dr. Keith Inglis, Pathologist to the Hospital. He was unable to detect any cholesterin in it; the section only showed a dense fibrosis.

Dr. Wardlaw, Bio-Chemist to the Hospital, made an estimation of the sugar content of his urine and reported it to be 1%.

The patient had always been a heavy drinker, as much as six or seven litres of beer each day, and a few years ago used to drink a considerable quantity of rum.

He was admitted under Dr. Leslie Dunlop and in one month's time was discharged with no glycosuria; all the papules were practically gone.

Reviews.

THE SECRETS OF ANCIENT EGYPT.

SIR ARMAND RUFFER, a trained pathologist, was Professor of Bacteriology in Cairo. He subsequently became President of the Quarantine Council in Egypt, a member of the Indian Plague Commission and held other important offices. He devoted his leisure during his long residence in Egypt to the study of ancient Egypt from the medical and physiological point of view. He accumulated an enormous mass of data and intended to devote the evening of his life to the proper presentation of this material when classified. A spirited man, he desired to do the best he could during the war. He accepted the invitation of Venizelos, then Prime Minister of Greece, to organize the sanitary service at Salonika. On returning from Salonika the ship in which he was travelling was torpedoed and he lost his life. His widow, Lady Ruffer, has arranged for the publication of the beautiful volume now presented,¹ which will be a mine of reference to those who wish to obtain accurate knowledge and a deeper insight into the fascinating history of the oldest civilization with which we are acquainted. The work consists of a set of essays on the histology of Egyptian mummies, on the nature of the diseases evidenced by the mummies, of the real nature of dwarfs in ancient Egypt, of dental disease and of the effects of consanguineous marriages amongst the Pharaohs, together with many other subjects.

In 1909 Sir Armand Ruffer found that by soaking the exceedingly hard tissues of mummies in a mixture of 100 parts of alcohol and 60 parts of a 5% solution of carbonate of soda he could soften them, that he could then dehydrate them with alcohol and chloroform, imbed them in paraffin and cut sections. In this way he prepared sections of muscles, blood vessels, skin, intestine, stomach, liver and other organs. He was even able to stain with hæmatoxylin and bring out the nuclei. A considerable amount of space is devoted to arterial disease, of which there was an abundance. It is noteworthy that neither he nor the great majority of observers have been able to find any trace of syphilitic disease in the remains of ancient Egypt. He gives incidentally an account of the way in which the embalmers did their work. By their relatively crude methods they both assisted and hindered the development of our knowledge of disease. They removed most of the organs and muscles, wrapped the viscera up again in more or less antiseptic wrappings and returned them to the body with varying skill. So hard, however, were the unsoftened tissues that they turned the edge of the microtome razor.

Details are given of appearances which can be identified with the results of pneumonia, atheroma, renal abscess and cirrhosis of the liver. In two members of the twentieth dynasty, somewhere about 1200 B.C., bilharzia eggs were

discovered, showing that the disease existed in ancient Egypt as it does to-day.

The essay on dwarfs is very interesting, as dwarfs were in great demand at the courts of the Pharaohs. The conclusion reached is that they were not really dwarfs, but deformed people affected with bone disease.

The work contains references to a pathological specimen dating from the Lower Miocene period and also an essay on prehistoric trephining, in both of which reference is made to countries other than Egypt. The essay on the teeth leads to the conclusion that in pre-dynastic Egypt the teeth were excellent, but that in dynastic Egypt—the Egyptians with which we are acquainted—who in all probability entered Egypt from Arabia, dental caries was very common. The diet was largely vegetable. The severity of the lesions of the jaw produced by diseased teeth, which could have been relieved by extraction of the teeth, indicates that dentists did not exist. There is no evidence either of the existence of tooth brushes or of serviceable artificial teeth.

The chapter devoted to the effects of consanguineous marriages is remarkable. Inheritance of the throne was through the female and in order to keep power in the hands of the family, the queen usually married her brother or half-brother, who then assumed executive authority. This practice was continued by the Ptolemys and was followed by a number of ancient peoples. As the facts are well known, it afforded Sir Armand Ruffer an excellent opportunity of testing the truth of the common belief that consanguineous marriages lead to degeneration. In the world's history there is in all probability no record of a more powerful race than the rulers of the eighteenth dynasty, from Ahmose I. (1580 B.C.) to Ikhnaton (1375 B.C.). Not only were most of them great warriors and statesmen, but Ikhnaton appears as a great reformer and monotheistic philosopher. Yet nearly all these emperors were the products of consanguineous marriages. Ruffer concludes that the evidence is against the current popular belief.

All those who take a broad survey of medicine, will be profoundly interested in reading this splendid work. It is often said that able men are not really missed and that the world can get on without them—a statement both true and untrue. Few people will peruse this volume without a feeling of profound regret that the courteous, cultivated gentleman, who endeared himself to all who knew him, was not spared to throw further light on a civilization which always attracts those who devote attention to it.

MEDICAL ART CALENDAR.

THE "Medical Art Calendar," published by Mr. J. Philip Kruseman, of The Hague, Holland, is an artistic production of high quality. Many years ago this calendar was instituted for the Netherlands Medical Association. The idea of embodying reproductions of paintings and engravings of the old Dutch masters and other schools of art in a calendar is probably not original. It is, however, a happy conception to select works of art dealing with medical and quasi-medical subjects to adorn a calendar for the medical profession. A few years ago this publication, having earned great popularity in Holland, was brought out in a special English edition. The Calendar for 1922 is the third English edition. It is a handsome wall calendar of usual dimensions, with twenty-seven leaves, each carrying a beautiful half-tone reproduction of the work of a great artist. Some of the pictures have been reproduced from the extraordinary collection in the Wellcome Historical Medical Museum. There are examples of the work of Jan Steen, of David Teniers, of Gerard Dou, of Thomas de Keyser. Some of the pictures are obscure types of early schools; some have been taken from the title pages of rare medical books of the seventeenth century. The alchemist, the barber-surgeon, the primitive dentist, the typical charlatan, all appear in half-gruesome, half-humorous representation. The reproduction is of very high order and the publishers are to be congratulated on the excellence of their work. Steps are being taken to secure the services of a distributing agent of this unique calendar in one of our cities.

¹ "Studies in the Palæo-Pathology of Egypt," by the late Armand Ruffer; Edited by R. L. Mudge, Assistant Professor of Anatomy, University of Illinois; 1921. Chicago: University of Chicago Press; Crown 4to., pp. 372, with numerous illustrations.

The Medical Journal of Australia

SATURDAY, APRIL 8, 1922.

The Future Medical Profession.

It is more than coincidence that the majority of retiring Presidents of the Australian Branches of the British Medical Association in their addresses discuss one or other aspect of preventive medicine. In the present issue Dr. Fourness Barrington deals in a masterly manner with a subject which he has made peculiarly his own. His term of office has been rendered conspicuously successful in that, in addition to the adequate performance of his presidential duties, he has instituted a policy and has founded a campaign. Dr. Barrington's solicitude for the welfare of the mother and her infant is a national concern. Throughout the twelve months he has worked assiduously and with unyielding determination toward his goal. Much has been accomplished in the direction of better education of the medical profession and of the public; the causes for the appallingly high maternal and infantile morbidity and mortality have been examined and to a great extent revealed and the remedies have been suggested. The Presidential Address represents a mile-stone on the journey that he has travelled, not the end of the journey. The Council of the New South Wales Branch and indeed the whole of the medical profession of Australia have the duty to continue the campaign until puerperal illness and death become rarities and until the first journey of each young Australian is rendered a safe one. There is still much earnest and hard work to be done before this set of problems in preventive medicine has found its corresponding set of solutions. Typhus fever has been stamped out in those parts of the old world where the gospel of cleanliness has been taught and accepted. Small-pox has vanished like magic in response to vaccination and complete control. Puerperal sepsis will be stamped out when those responsible for the safety of the woman in pregnancy and parturition have learned their lesson and have

moulded their practice on the doctrines of surgical asepsis and the avoidance of meddling midwifery. Dr. Barrington has indicated how various agencies must cooperate to safeguard the lives of the unborn infant and its mother. He has demanded this co-operation early in the pregnancy, in order that preventive measures may be employed as soon as signs appear to indicate that hazardous curative measures will otherwise have to be applied at a later date. The babies of to-day are the citizens of a few years hence. Dr. Barrington's campaign is planned to insure a strong, virile, Australian race when other nations are languishing. The medical profession as a whole must help to banish preventible death in child-birth.

Dr. R. G. Scott, in his interesting reminiscent discourse, also recognizes the flow of the tide. In the early days of which he writes, the medical profession was scarcely concerned with prophylaxis. Under relatively exceptional circumstances the practitioner was called upon to render some service to the responsible health authority in a seemingly vain endeavour to improve the health conditions of the people. Gradually the idea has forced itself on sociologists that the national health cannot be preserved and maintained by spasmodic, fitful, perhaps casual efforts of individual practitioners, supplementing the endeavours of the medical officers of the Health Departments. It is not even sufficient that every practising member of the medical profession should be required to lend regular aid to the authorities. The medical profession of the future will certainly adopt as part of its function procedures in preventive medicine. Hitherto there has been a form of conflict between the activities of a medical practitioner in his relation to his patient and his activities in his relations to the health authority as representing the public. He has resisted notification of specified infective processes until compulsion has removed his scruples. The patient has been slow in realizing that the small duties required of the practitioner in connexion with the notification of a handful of diseases is actually an essential in the process of prevention. With this recognition and with the introduction of a more extended collaboration in programmes aiming at the stamping out of groups of diseases, the patient will learn to refrain from objecting to measures of this kind, even though they

occasion a slight degree of discomfort. Spontaneous action will replace compliance with regulations and laws. Then will come the demand of the individual in the community to be protected and the general practitioner will be expected to guide his patient along lines of safety. In the past the general practitioner reinforced to a slight extent the public health authority in the struggle against preventible disease. In the future he will become the first line of defence and all other forces will be held in readiness behind him to supplement and support his attacks.

THE DELINQUENT CHILD.

THE problem of the mentally defective child has received a considerable amount of attention during recent years. A clearer understanding has been obtained by the introduction of the so-called mental age tests and by the recognition of the dependence of intellectual and moral qualities on the development of the supra-granular layer of the brain. The study of the delinquent child in the children's courts and in the special institutions for mentally deficient children has led to a realization of the psychological nature of many types of defect. Progress has been impeded to some extent by the fact that the control of the abnormal child is entrusted in the first instance to the departments of public instruction. It happens that the existence of a mental defect is detected in some individuals in early childhood. As a result of this fact the short-sighted authorities have espied in mental deficiency a problem of childhood, instead of a problem affecting individuals throughout life. Some of these individuals can be trained to become relatively useful members of society, provided that a perpetual check is kept over them until the day of their death. The so-called "education authority" measures the mentality of its charge-lings by their ability to learn. This means that moral defects are ignored and delinquencies, often portending serious crimes in adolescence, are treated like the naughtiness of a normal child. It is quite obvious that until the several aspects of the problem are coordinated, criminals, prostitutes and social derelicts will continue to be recruited from the ranks of unrecognized mental defectives.

Not every child who is perverse, who is lazy, who is dull, who is naughty or who is recalcitrant, is mentally defective. Conversely, not every bright and intelligent child is of normal mentality. Dr. Groves Blake Smith¹ has made an attempt to indicate the manner in which the psychopathic child is distinguished from the normal child in the Washington University Medical School Dispensary. He sweeps aside in one large group all children with

deficient cerebral development, with traumatic or pathological lesions and with the residual effects of previous infective processes. He would hand over to the paediatrist all these children. Some of the lesions may be amenable to treatment and presumably the mental processes will be saved after the cure of the organic lesion if the arrest in development has not been of long duration. He does not, in our opinion, bring out with sufficient emphasis that not infrequently the inherited or acquired defect is so slight that it is recognizable only with difficulty. Moral, social or intellectual shortcomings indicate the psychopathic quality of the defect, but the organic basis, if overlooked, will persist in spite of all endeavours to influence the child's environment. Dr. Smith's next class is defined as children whose maladjustment is the result of so-called functional causes, the majority of which can be eradicated. He illustrates this type by reciting the history of a boy of eight years, who displayed excellent cooperation, concentration and judgement on being subjected to the tests. His mental age level was nine years. He was lazy, cruel, cowardly and vicious. He committed sexual acts with little girls and boys. He stole and one occasion set a house on fire. His mother was a prostitute. Whether this child's behaviour and moral qualities were the result of a vicious environment or not is an open question. Although Dr. Smith classes him among children whose maladjustment is the result of so-called functional causes, it would appear not improbable that an inherited defect, a definite organic arrest of cerebral development, might underlie the psychical make-up. He points to a lack of the proper sense of dependence as a cause of mental trouble. Here Dr. Smith passes almost insensibly from the pathological to the normal. The psychopathic child, no doubt, need not be an abnormal child. It may be a normal child in an abnormal environment.

Much more information can be gleaned from a thoughtful and altogether admirable article by Dr. Robert Hutchison.² This author describes in a very fascinating manner the "solitary child." He insists that "only child" and "spoilt child" are not synonymous terms. The solitary child is a normal creature, reacting normally to stimulation which does not belong to childhood. The solitary child is brought into association with grown-up people and is standing "intellectually on tip-toe" all the time. Underneath the precocity is found the physical result of nervous strain. The solitary child has too much attention paid to it and is led to regard itself as the most important person in the house. Dr. Hutchison finds that this demand for limelight incites the child to resort to strange devices. When the solitary child is an only child, the parents or guardians are unduly anxious about its health. The pathology of the solitary child is to be studied in the parents and in the home, rather than in the child. The mother often over-studies her child, with the result that mothercraft becomes exaggerated. As Dr. Hutchison puts it, the only thing she lacks is a saving sense of humour. The child becomes

¹ *Illinois Medical Journal*, November, 1921.

² *The Lancet*, January 28, 1922.

priggish; a spirit of opposition is awakened and it becomes introspective, emotional, hypochondriacal, troublesome and disobedient. The tricks of the solitary child are well known; every practitioner suffers acutely from the tantrums of the "little devil" who kicks, screams and bites when an attempt is made to examine him. At times the solitary child carries an inherited defect and the mental picture becomes more complicated and less promising. In its pure form solitary childism is eminently curable, but if neglected or misunderstood, it tends to merge into a psychopathic condition which may simulate very closely a real mental defect. In the problem of the mentally defective child, therefore, it is necessary to study and treat the parent, or rather the methods adopted by parents in the upbringing of the infant.

ACUTE CEREBELLAR ENCEPHALITIS.

ACUTE non-suppurative inflammation of the encephalon may be caused by many distinct infective agents and may assume many forms according to the type of inflammation and to the situation of its greatest intensity. While these conditions were but a few years ago regarded as aberrant forms of acute poliomyelitis, recent clinical and pathological investigations have shown that so simple an explanation cannot cover all the varieties. The recognition of *encephalitis lethargica*, of a specific form of poli-encephalitis, of a primary hæmorrhagic encephalitis and possibly of the disease called "X disease" has attracted much attention to this subject and has led to the collection of a considerable amount of casuistic information and some data dealing with the bacteriology and pathology of these conditions. It is abundantly evident that none of these diseases is new; their differentiation from more or less similar affections alone is a recent achievement. After the 1890 influenza pandemic, there were recorded many instances of an acute encephalitis, presumably of toxic origin, connected in some way with influenza. Some accounts of these illnesses coincide closely with those of lethargic encephalitis now appearing in almost every medical journal in the world. It must be remembered that the study of acute poliomyelitis is of relatively recent date. A generation ago the acute stage was usually missed and the disease was familiar only in its chronic stage and in the stage of permanent, fixed destruction.

In the year 1915 Professor J. P. Crozer Griffith ransacked the literature for records of an acute form of encephalitis in children in which the cerebellum was the site chiefly affected. He found twenty-one such records. Since that date ten further records have been published, making thirty-one in all. He has observed this condition himself in four children and now endeavours to summarize the knowledge collected.¹ He points out that several instances of a cerebellar form of the ordinary epidemic encephalitis have been seen in adults. In

addition, myoclonic forms of encephalitis, with tremor, but without ataxia, have been observed. These are quite distinct from acute cerebellar encephalitis. He also excludes the condition described as choreiform or choreo-ataxic or choreo-athetotic encephalitis, as being distinguishable from the affection of which he writes. The differentiation, however, is based more on the distribution of the inflammation than on any ascertained characters of the morbid histology or ætiology of the affections. From his own experience and from the records of the published symptoms and course he endeavours to build up a description of a typical attack. The onset is acute. The first signs are unconsciousness, often heralded by vomiting or convulsions. The unconsciousness lasts for a few days and, as it passes off, it is noted that speech is absent and that the mental processes are impaired. Soon the power of speech returns, but defects in enunciation occur. Ataxia of the limbs may vary in degree and there may be present ataxia of the head and trunk. The little patient may be unable to walk at all, or the gait may be staggering. As a rule, the mental defect disappears at an early stage, but at times it may be permanent. The ataxia and speech disability often persist for a considerable time. Nodding of the head, regarded as a manifestation of static ataxia, has been observed in several instances. Among the less common symptoms are nystagmus, strabismus, optic neuritis, loss of sphincter control, paresis, vertigo and disturbance of sensation. It would seem that the knee jerks are usually active or normal, but ankle clonus has been noted. All the patients recovered from the immediate effects of the attack. Professor Griffith mentions that two patients died some years later after signs of mental failure had progressed steadily. Unfortunately, he does not mention whether a thorough histological examination of the brains of these two patients was carried out. In these circumstances he finds himself unable to establish a definite pathology of the condition. He has reason to believe that the acute cerebellar encephalitis is a form of lethargic encephalitis, although in the thirty-one attacks there does not appear to have been any close connexion with a particular epidemic. The prognosis is good as far as life is concerned, but complete recovery does not occur in about one-quarter of the patients, while in the others it appears after a varying time.

AUSTRALIAN ARMY MEDICAL CORPS.

MEDICAL officers of the Australian Army Medical Corps, of the Australian Army Medical Corps Reserve, of the Reserve of Officers and of the Retired List are being invited by the Director-General of Medical Services to forward to the Deputy Director of Medical Services in their respective Military Districts a list of their professional degrees and diplomas in order that the corresponding letters may be appended to their names in subsequent editions of the "Forces List." It is hoped that all medical officers will comply with this request without loss of time.

¹ *The American Journal of the Medical Sciences*, December, 1921.

Abstracts from Current Medical Literature.

PATHOLOGY.

Purpura.

S. PHILLIPS BEDSON (*Journal of Pathology and Bacteriology*, January, 1922), working on guinea-pigs, has carried out experiments with blood-platelet anti-serum, especially concerning its specificity and rôle in the experimental production of purpura. He has shown that anti-platelet serum, when inoculated into the animal for which it is specific, produces purpura, whereas the sera prepared against the other blood elements, such as red cells, leucocytes, serum, do not. The destruction of the platelet or its removal from the circulating blood is brought about by anti-platelet. The fate of the platelet is unknown. The other antisera do not produce this change. Obviously this is one of the factors concerned in the production of purpura. That it is not the only one is shown by experiments with "agar-serum." Although by this means the platelet counts can be very considerably diminished, hæmorrhages do not occur. There must therefore be some other change occurring in purpura. This other change is damage to the capillary endothelium. Histological examination of the tissues from purpuric animals supports this contention, as change in the vascular endothelium similar to those found in experimental scurvy can be detected, namely, a swollen and edematous condition of these cells. It would seem that in purpura produced by means of an anti-platelet serum the sequence of events in the production is as follows: The capillary endothelium is first of all damaged and later, when the platelets have been greatly reduced in number in the circulating blood, a leakage of red cells through the capillary wall into the surrounding tissues takes place. Had the platelets been present, hæmorrhages would not have occurred because their presence in the outer, more slowly moving, stream, together with the leucocytes, would have prevented the rapidly moving central stream of red cells from coming into contact with the endothelium and of finding out its weak spots. They would also have helped in making good the deficiencies of the vessel wall caused by the endothelial damage.

Sulphæmoglobinaemia.

V. R. MASON AND F. D. CONRAY (*Bulletin of the Johns Hopkins Hospital*, December, 1921), in an account of recent investigations on sulphæmoglobinaemia, discuss the pathogenesis of the condition. Since in many instances constipation was a prominent symptom, studies were made to determine whether increased quantities of hydrogen sulphide or an increased amount of hydrogen-sulphide-producing bacteria were present in the bowel. The results of such investigations were not convincing and fur-

ther attempts to explain the malady by increased production of hydrogen sulphide in the alimentary tract were abandoned. The suggestion of Steensma that the presence of nitrites in the blood might be the basis of methæmoglobin production was apparently proved by van den Bergh and Gutterink for methæmoglobinaemia. Clarke and Hurtley later demonstrated that the addition of powerful reducing agents, such as nitrites, to blood also greatly accelerated the production of sulphæmoglobin in the presence of minute traces of hydrogen sulphide. Wallis therefore followed these leads in an attempt to elucidate the pathogenesis of sulphæmoglobinaemia. He investigated the saliva of four patients suffering from this condition and in each instance found a nitrite-producing bacillus and increased amounts of nitrites. He demonstrated, furthermore, that the serum of each patient contained a reducing body capable of converting oxyhæmoglobin into reduced hæmoglobin. He assumed, therefore, that the malady was dependent on the absorption by the blood of nitrites from the buccal cavity and of small amounts of hydrogen sulphide from the gut. This hypothesis is attractive, but other workers, including the authors, have failed to confirm the results of Wallis's investigations. The problem of the method of the production of sulphæmoglobinaemia in man, therefore, is not solved, although the evidence at hand supports to some extent the opinion of van den Bergh that sulphides, formed in the bowel in some manner, gain access to the blood.

Hydrocephalus.

J. C. NAÑAGAS (*Bulletin of the Johns Hopkins Hospital*, December, 1921) records the results of experimental studies on hydrocephalus. Hydrocephalus was produced in kittens by the injection of a 10% suspension of lamp-black in physiological saline solution into the sub-arachnoid space at the *cisterna cerebello-medullaris* through the occipito-atlantoid ligament. Injections were also made directly into the lateral ventricles. The pressure of cerebro-spinal fluid in kittens in which an internal hydrocephalus has been produced, was considerably higher than that of normal kittens; an average difference of fifty millimetres of cerebro-spinal fluid was found to be present. Intravenous injection of a strongly hypertonic solution of sodium chloride in hydrocephalic animals produced a brief initial rise in the pressure of the intra-ventricular cerebro-spinal fluid, followed immediately by a marked depression. The pressure at times decreased below that of the atmosphere. This phenomenon is probably to be explained by the apparently rapid absorption of the cerebro-spinal fluid from the dilated cerebral ventricles. Intravenous injection of hypotonic solution (distilled water) in hydrocephalic kittens was invariably followed by a marked and sustained in-

crease in the pressure of the cerebro-spinal fluid. This result was possibly due to a rapid elaboration of fluid by the choroid plexuses or to an increased transudation of fluid through the ventricular walls. Intra-ventricular absorption of cerebro-spinal fluid took place in these hydrocephalic kittens; the pathway of escape was through the ependyma into the underlying capillary network. This absorption of cerebro-spinal fluid was hastened by the intravenous administration of strongly hypertonic solutions. Absorption of the cerebro-spinal fluid was similarly found to be taking place through the ventricular ependyma in normal kittens. The choroid plexuses took no part in the intra-ventricular absorption of the cerebro-spinal fluid.

Salivary Tumour.

J. BERGER AND J. MAGROU (*La Presse Médicale*, November 30, 1921) report a case of salivary tumour of unusual type. The growth was the size of a walnut and was situated in the left carotid region on a level with the superior border of the thyroid cartilage. No functional derangement accompanied the appearance of the tumour, which was uniform, hard, not adherent to the skin and freely movable on the deeper tissues. When removed the tumour showed nothing resembling an excretory duct and on histological examination the authors were surprised to find that it had the structure of a human sub-maxillary gland absolutely normal throughout almost its whole extent. In only a small portion of one lobe did the gland present the myxomatous appearance seen in mixed salivary tumours the epithelial origin of which was recognized by Masson and Peyron. The authors were struck by seeing the development, towards the age of forty years, of a salivary gland of almost normal appearance and occupying an abnormal situation. They think it must be an aberrant lobule of the sub-maxillary gland which, either on account of degenerative changes or some other cause which cannot be explained, has slowly grown in two years to the size of a walnut, at the same time preserving almost entirely the normal appearance of a salivary gland.

The Wassermann Reaction with Unheated Human Sera.

C. H. BROWNING, E. M. DUNLOP AND E. L. KENNAWAY (*Journal of Pathology and Bacteriology*, January, 1922) state that under the conditions generally observed in performing the Wassermann test, any unheated normal serum will react, provided that a sufficient concentration of alcohol is present. This amount of alcohol does not in general affect the inhibitory power of the antigen by itself on complement. Sometimes unheated normal serum, together with alcohol, in the absence of any added tissue lipid, will yield a reaction, but in other cases the presence of added lipid is required to bring about this

result. Occasionally unheated non-syphilitic sera from healthy individuals may react with the dilution of human heart-cholesterol commonly employed. Hence it is not permissible, with a view to rendering the reaction more "delicate," to substitute unheated for heated serum in carrying out the tests under the conditions ordinarily observed.

PÆDIATRICS.

Thymus Gland.

G. J. NOBACK (*American Journal of Children's Diseases*, August, 1921), from the study of sixty-five fetuses and full-term children by means of dissections, graphic reconstructions and free-hand sections, finds that the lobation of the thymus is determined early in the fetal life and the establishment has obviously no effect upon it. The thymus in the fetus shortly before birth and in the new-born is predominantly of the cervico-thoracic type, i.e., its position is intermediate between the cervical location in the embryo and the thoracic location of the older infant, child and adolescent. The thymus in the fetus shortly before birth and in the new-born child has a typical form and constant relations. Its lateral surfaces are convex and bulge against the medial surfaces of the lungs. The lungs very rarely extend at all on its anterior surface and the thymus very rarely extends at all on the anterior surface of the right ventricle. The thymus in live-born infants has typical form and relations, which are similar to those found in young children. It is elongated and moulded so that its anterior, lateral and posterior surfaces bear the impress of all the organs with which it is in contact. Its lateral surfaces usually show marked convexities, which are occupied by the lungs, which pass over the anterior surface of this organ. Unlike the fetal thymus, it usually extends more inferiorly, passing over the right ventricle. The change from the broad or fetal type of thymus to the elongated and moulded type found in the new-born and in the young infant bears a direct relation to the establishment of respiration and is dependent on the expansion of the lungs. The organ is compressed from side to side by the medial surfaces of the expanding lungs. It is compressed antero-posteriorly by the anterior borders of the lungs, which become much thickened early in the establishment of respiration as they gradually overlap the thymus. In some instances the thymic substance may extend posteriorly at birth to such an extent that the structures situated there are compressed by it. This may be due to an unusually large thymus or to a very narrow superior thoracic aperture which will not allow the thymus to protrude into the cervical region as it is compressed by the expanding lungs. The descriptions and

illustrations in the literature of the thymus in the new-born child show great confusion. They include both the fetal and infantile types and the distinction between the two has evidently passed unrecognized. The type of thymus which is the more frequently described as characteristic of the new-born and the infant, is the one which the preceding data indicate is usual for the fetus and still-born as contrasted with the living infant.

Bacteriology of Pneumonia.

A. B. LYON (*American Journal of Diseases of Children*, January, 1922) examined bacteriologically the sputum, blood, pleural fluid and lung of ninety-eight children with lobar pneumonia, fifty-two with broncho-pneumonia and fifteen with post-pneumonic empyema. The ages of the patients were twelve years or less. He found in lobar pneumonia or empyema pneumococcus Type 1 in 29.9%, pneumococcus Type 2 (including atypical) in 3%, pneumococcus Type 3 in 7.1% and pneumococci of Group 4 in 37.7%. The figures represent a higher percentage of fixed types than the literature suggests, but there is a reasonably close correspondence between these and the findings in a parallel series of cases in adults. The aetiology of lobar pneumonia in infants and children seems to follow in a general way that in adults for a given community at a given time. Studies of comparative mortality suggest that the child possesses a better natural immunity against pneumococcus, type for type, than does the average adult. In broncho-pneumonia the fixed types of pneumococcus are much less common than in lobar pneumonia. Common mouth forms are relatively much more common. Regardless of type, the general mortality for broncho-pneumonia is much greater than for lobar pneumonia. This is probably due to the conditions of origin and circumstances surrounding the former disease. *Streptococcus hemolyticus* and *Staphylococcus aureus* have been common in broncho-pneumonia and have led to a particularly high mortality. Again there has been an extraordinary tendency to the development of empyema in infections with pneumococcus Type 1. In nearly 38% of patients with pneumonia of this type developed this complication. Numerically it outranked any other cause of empyema in the series by about six times.

Transfusion in Infants with Malnutrition.

S. B. BURK AND L. FISCHER (*Medical Record*, October 29, 1921) find that a marked diminution in the quantity and quality of blood in infancy or adult life is benefited by transfusion and its use should become an every-day procedure. They report a small series of fourteen transfusion performed on ten infants aged from nine days to six months. The blood injected was a 0.3%

citrated solution; its amount was thirty cubic centimetres and the average time of injection about ninety seconds. Following transfusion, there was marked improvement in four infants, a slight improvement in six and none in two. The reactions were severe in four infants, moderately severe in seven and slight in three. They conclude that: (i.) Transfusion of blood is a simple operation and a valuable therapeutic agent. (ii.) It is oftentimes a life-saving procedure in the treatment of diseases of the hæmopoietic system. In the presence of so-called hæmorrhagic diseases of children the patients are greatly benefited by this operation. (iii.) Transfusion of blood is valuable in the treatment of malnutrition and of the cachexias following the acute infectious diseases. It improves the general condition of patients with gastro-intestinal disturbances, who do not improve with formula feedings or the use of mother's milk. This is particularly noticeable when marked dehydration is present following failures after the use of hypodermocystis, rectal instillations and venous infusions. (v.) Transfusion improves the prognosis in premature infants. (vi.) It is best performed in infants by using the superior longitudinal sinus because of its large calibre and its surface location.

Ammonia Dermatitis.

ALL those who treat infants and young children encounter with more or less frequency instances in which the diapers, after having been wet with urine for several hours, give off the odour of ammonia. The odour frequently is faint and the condition occurs in infants otherwise well and thriving. In some cases the ammoniacal odour is very pronounced and accompanied by irritation of the skin of the diaper region, usually more marked over the skin of the buttocks and inner side of the thighs. The lesion may consist only of diffuse redness, but not infrequently vesicles and papules with more or less excoriation occur. There seems no doubt that the dermatitis is caused directly by the ammonia. From a number of such infants, J. V. COOKE (*American Journal of Diseases of Children*, November, 1921) has isolated a urea spitting organism in the faeces, an aerobic, non-motile, Gram-positive bacillus which does not ferment the ordinary sugars nor form spores. Moderate degrees of acidity inhibit its growth. This explains the rarity of the condition in the breast-fed and in those with much sugar in the diet. The organism is found regularly in the stools of infants with this form of dermatitis and of older children with enuresis, in whom a similar dermatitis may occur. The organism is seldom present in normal infants, but is not unusual in older normal children. Treatment is directed to the diet, but mainly to the diaper itself. After washing and thorough rinsing in water the diaper is wrung out and dried after a final rinsing in a 1 in 5,000 solution of mercuric chloride or a 1 in 20 solution of boracic acid.

British Medical Association News.

ANNUAL MEETINGS.

NEW SOUTH WALES BRANCH.

THE ANNUAL MEETING OF THE NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Buildings, 30-34, Elizabeth Street, Sydney, on March 31, 1922. Dr. FOURNESS BARRINGTON, the President, in the chair.

Annual Report.

THE HONORARY SECRETARY moved and Dr. ANDREW DAVIDSON seconded that the Annual Report of the Council be taken as read and received. The text of the report is reproduced below:

ANNUAL REPORT OF THE COUNCIL, MARCH 31, 1922.

THE COUNCIL presents the following report upon the work of the Branch for the year ended March 31, 1922:

Membership.

The membership of the Branch is now 1,203 as compared with 1,180 at the date of the last Annual Report, showing a net increase of 23.

The additions have included figures as follows: Elections and resumption of membership, 87; removals into the area of the Branch, 21.

The losses have included: Resignations, 10; removals out of the area of the Branch, 42; default in payment of subscription, 18; expulsion, 1; deaths, 14.

The losses by death have been: Dr. S. T. KNAGGS, Dr. W. IRWIN, Dr. C. A. BURFITT, Dr. L. W. BICKLE, Dr. W. R. CLAY, Dr. J. MACKENZIE, Dr. GATEWARD C. DAVIS, Dr. H. T. S. BELL, Dr. B. A. VEECH, Dr. A. N. CHENHALL, Dr. G. A. PAUL, Dr. F. G. CONNOR, Dr. L. B. LANCASTER, Dr. R. E. GRIGSON.

Meetings.

Ten ordinary meetings of the Branch, including the Annual General Meeting, five extraordinary meetings and seven clinical meetings were held. The average attendance was 75.9. Clinical meetings were held at the Royal Alexandra Hospital for Children, Royal Prince Alfred Hospital, Sydney Hospital, Coast Hospital, Royal North Shore Hospital of Sydney and the Psychiatric Clinic, Broughton Hall. The business of the ordinary and clinical meetings included twenty-eight papers and addresses and numerous reports of cases, demonstrations and exhibits, as well as lantern demonstrations.

Representation.

The Branch was represented as follows:

- (a) *Council of the British Medical Association*: Dr. H. A. FRANCIS (resigned August 26, 1921), Sir T. JENNER VERRALL (nominated November 15, 1921).
- (b) *Representative Body*: Dr. R. H. TODD.
- (c) *Federal Committee of the British Medical Association in Australia*: For the year 1921: Dr. J. A. DICK, C.M.G., and Dr. R. H. TODD. (Dr. D. THOMAS substitute for Dr. R. H. TODD at the Federal Committee Meeting of July 20, 1921). For the year 1922: Dr. J. A. DICK, C.M.G., and Dr. R. H. TODD.
- (d) *Australasian Medical Publishing Company, Limited*: Dr. W. H. CRAIGO, PROFESSOR F. P. SANDES, Dr. R. H. TODD.
- (e) *Council of Bush Nursing Association*: Dr. FOURNESS BARRINGTON.
- (f) At the invitation of the Director-General of Health, Dr. D. LUKER was appointed Delegate of the Branch to attend the First Annual Conference of the Public Health Association of Australasia, Melbourne, September 7 to 10, 1921.
- (g) At the invitation of the Director-General of Health, Dr. E. H. MOLESWORTH was appointed Delegate of the Branch to attend the Commonwealth and States of Australia Venereal Diseases Conference, Melbourne, February 3, 1922.

Council.

(a) The attendance of Members of the Council and of the Standing Committees of the Council was as set out in the table on the next page.

(b) The representatives of the Local Associations of Members appointed on the invitation of the Council to attend the regular quarterly meetings of the Council were as follows: Dr. C. A. HOGG (Central Southern), Dr. K. S. MACARTHUR BROWN (Central Western), Dr. A. M. GLEDDE (City), Dr. F. G. N. STEPHENS (Eastern Suburbs), Dr. F. O. STOKES (Eastern District), Dr. W. F. SIMMONS (Illawarra Suburbs), Dr. T. J. HENRY (North-Eastern), Dr. W. B. DIGHT (Northern District), Dr. F. GUY GRIFFITHS (Northern Suburbs), Dr. J. HOETS (South Sydney), Dr. F. C. ROGERS (Western Suburbs), Dr. E. H. BURKITT (Western).

B.M.A. Building.

Dr. W. H. CRAIGO continued in his capacity as "Premises Attorney" and gave the same assiduous and skilful attention to the interests of the Association as he has always given since he first accepted this responsible position in the year 1911.

The Library.

Dr. J. ADAM DICK, C.M.G., was re-appointed Honorary Librarian.

Donations of books and periodicals have been received from the AUSTRALASIAN MEDICAL PUBLISHING COMPANY, LIMITED, SIR CHARLES MACKELLAR, K.C.M.G., Dr. W. G. ARMSTRONG, Dr. A. H. TEBBUTT, D.S.O., Dr. C. N. PAUL, Dr. F. BARRINGTON.

Affiliated Local Associations of Members.

The following is a list of the Local Associations of Members, with the names of their Honorary Secretaries:

Balmain District: Dr. W. B. GRANT.
Border: Dr. R. AFFLECK ROBERTSON.
City: Dr. H. A. RIDLEY.
Central Northern: Dr. H. G. ALLEN.
Central Southern: Dr. G. A. BUCHANAN.
Central Western: Dr. K. S. MACARTHUR BROWN.
Eastern District: Dr. H. T. MARSH.
Eastern Suburbs: Dr. W. EVANS.
Illawarra Suburbs: Dr. W. F. SIMMONS.
Northern District: Dr. E. W. BUCKLEY.
North-Eastern: Dr. R. V. GRAHAM.
Northern Suburbs: Dr. E. A. R. BLIGH.
Southern District: Dr. S. H. WEDDON.
South-Eastern: Dr. H. H. LEE.
South Sydney: Dr. R. A. R. GREEN.
Western Suburbs: Dr. J. F. WALTON.
Western: Dr. J. T. PATON.

Annual Meeting of the Delegates of the Local Associations of Members with the Council.

The Tenth Annual Meeting of the Delegates of the Affiliated Local Associations with the Council was held on October 7, 1921, at the B.M.A. Library, Sydney, the proceedings of which were reported in THE MEDICAL JOURNAL OF AUSTRALIA, 1921, Volume II., page 358.

The delegates were as follows: Dr. R. AFFLECK ROBERTSON (Border), Dr. N. J. DUNLOP (Central Northern), Dr. G. A. BUCHANAN (Central Southern), Dr. K. S. MACARTHUR BROWN (Central Western), Dr. A. M. GLEDDE (City), Dr. F. O. STOKES (Eastern District), Dr. F. G. N. STEPHENS (Eastern Suburbs), Dr. W. F. SIMMONS (Illawarra Suburbs), Dr. O. A. A. DIETHELM (North-Eastern), Dr. E. B. FITZPATRICK, substitute for Dr. E. W. BUCKLEY (Northern District), Dr. F. GUY GRIFFITHS (Northern Suburbs), Dr. J. KEER (South Eastern), Dr. W. W. MARTIN (Southern District), Dr. J. G. W. HILL (South Sydney), Dr. E. H. M. STEPHEN (Western Suburbs), Dr. J. T. PATON, substitute for Dr. L. W. ROBERTS (Western).

Sections for Special Branches of Medical Knowledge.

During the year two Sections were formed under the Rules of the Branch for Sections for Special Branches of Medical Knowledge, namely, a Section of Pædiatrics and a Section of Hygiene and Preventive Medicine. A meeting of the Section of Pædiatrics was held in conjunction with an ordinary meeting of the Branch on December 2, when the subject of "Infantile Mortality in New South

Wales" was discussed. Arrangements have been made for a meeting of the Section of Hygiene and Preventive Medicine to be held in conjunction with a meeting of the Branch on April 7 for a discussion on "Plague."

"The Medical Journal of Australia."

By direction of the Council a letter was sent to the Directors of the Australasian Medical Publishing Company, Limited, conveying the congratulations of the Council on the improved appearance of THE MEDICAL JOURNAL OF AUSTRALIA resulting from the Company having undertaken the type-setting and composition of the JOURNAL with its own machinery and staff, commencing with the issue of October 8, 1921.

Contract Practice.

(a) Friendly Society Lodges.

(1) The amendments of the approved Common Form of Agreement between Medical Officer and Friendly Society Lodge, which came into operation on April 1, 1921, have adapted the agreement to the economic changes which have taken place in recent years, with the result that the relations between medical officers and the lodges have continued to be satisfactory and the high standard of medical service established with the introduction of the agreement in 1913 has been maintained.

(2) At the instance of the Friendly Societies' Association, a conference with the Council was held on August 12, 1921, when certain proposals of the Friendly Societies' Association for further amendment of the Common Form of Agreement were discussed. The proposals were submitted to all the local associations of members for consideration, with a view to their being dealt with at the Annual Meeting of the Delegates of the Local Associations with the Council. The discussion on them at that meeting was reported in THE MEDICAL JOURNAL OF AUSTRALIA, October 22, 1921, page 358, and the several resolutions passed

at the meeting were subsequently considered by the Medical Politics Committee and by the Council, with the result that, so far as amendment was concerned, none of the proposals was approved. On the other hand, two proposals of the Friendly Societies' Association were approved, as follows, namely:

(i.) That in cases coming under Clauses 14, 15 and 16 (whereby the medical officer undertakes to administer anaesthetics where necessary, to attend fractures and dislocations and, when required, to give special services) the medical officer should, wherever it is possible to do so, make arrangement in regard to the fee to be charged before the service is rendered.

(ii.) That in regard to Clause 9 (which provides that certificates other than those required by the lodge for its own use shall be paid for as per arrangement between the member and the medical officer) the charge to be made for such other certificates, provided they are required by the member for friendly societies purposes (as, for instance, to enable him to claim sick pay from some other lodge) is to be 2s. 6d. in all cases. Previously, where the medical officer gave a certificate to a member on his list to enable him to claim sick pay from another lodge, he was entitled to charge 10s. 6d..

The medical officers of lodges were advised in accordance with both these rulings and the Council trusts that they will be strictly observed, as being the result of very careful consideration and conducive to the smooth working of the Common Form of Agreement.

A further conference has been asked for by the Friendly Societies' Association and will be held at an early date.

(3) The following resolutions passed at the Annual (1921) Meeting of Delegates of the Local Associations with the Council were approved by the Council, viz.:

(a) Examination of Applicants for Lodge Membership:

That all applicants for lodge membership be examined only at the doctor's surgery.

ATTENDANCE OF MEMBERS OF THE COUNCIL AND OF THE STANDING COMMITTEES OF THE COUNCIL.

Office-Bearers.	Council.	Executive and Finance Committee.	Ethics Committee.	Organization and Science Committee.	Medical Politics Committee.	Medical Journal Sub-Committee (Executive and Finance Committee).
DR. GEORGE ARMSTRONG	6	11	—	—	—	11
DR. J. E. V. BARLING	5	—	—	11	—	—
DR. F. BARRINGTON (President)	7	11	7	1	15	9
DR. C. B. BLACKBURN, O.B.E. (Ex-President)	6	4	9	—	4	1
DR. A. J. BRADY	5	—	8	—	—	—
DR. W. H. CRAGO (Honorary Treasurer; Premises At- torney)	7	12	6	1	10	11
DR. F. BROWN CRAIG	6	—	—	14	—	—
DR. A. DAVIDSON	4	—	8	—	—	—
DR. J. A. DICK, C.M.G. (Honor- ary Librarian)	5	10	—	—	15	—
DR. SINCLAIR GILLIES	4	—	4	—	—	—
DR. SYDNEY JAMIESON	5	8	—	—	—	—
DR. C. H. E. LAWES	6	—	—	—	12	—
DR. T. W. LIPSCOMB	7	9	8	—	15	—
DR. W. F. LITCHFIELD (Honor- ary Medical Secretary) . .	5	—	—	11	—	—
DR. W. C. MCCLELLAND	7	—	—	—	11	—
DR. A. A. PALMER	7	—	10	—	—	—
DR. S. A. SMITH ¹	6	—	—	—	6	—
DR. D. THOMAS	2	4	—	—	—	—
DR. R. H. TODD (Honorary Sec- retary) ²	3	7	6	7	6	7
DR. R. B. WADE	7	—	11	5	—	—
Number of Meetings Held..	8	12	11	14	15	12

¹ Absent part of the year, Technical Commission of Inquiry, Broken Hill.

² Absent on leave, May to October, 1921.

(b) Common Form of Agreement, Clauses 14 and 18:

That in the case of any surgical procedure where an anæsthetic (local or general) is indicated or requested by the patient, the medical officer is entitled to charge a fee for the operation in addition to that for administering the anæsthetic; otherwise, that the decision in the matter be left to the individual practitioner.

(b) Collieries.

The adjustment of the rates for contract attendance on colliery employees to the increased cost of medical practice and drugs, referred to in the last Report of the Council, has been effectively brought about in the southern collieries through the instrumentality of the South-Eastern Medical Association.

Regulations.**(1) Memorandum and Articles of Association.**

Alterations of the Memorandum and Articles of Association were made as follows:

(a) *Memorandum, Clause 4:* Increasing the maximum rate of interest from £5 to £6 per centum per annum payable by the Association on money borrowed from or lawfully due to any member.

(b) *Articles of Association:* (i.) Providing for nine days' notice (including the day of notice) to be given of a general meeting instead of seven days (excluding the day of notice) (Article 16). (ii.) Substituting "was put into the post office" for "would be delivered in the ordinary course of post" in determining the time at which a notice is served (Article 64). (iii.) Enabling the two meetings required by law to be held for passing a special resolution to be convened by one and the same notice (Article 16).

(2) Remuneration of Ships' Surgeons.

The following resolution was passed at the instance of the Federal Committee in accordance with the procedure adopted in the other Branches in Australia, viz.:

That the remuneration of ships' surgeons should be at a rate not less than twenty-five pounds (£25) a month with the right to charge fees for attendance on passengers other than steerage passengers.

(3) Advertisements in Newspapers.

The following recommendation of the Annual (1921) Meeting of Delegates of the Local Associations with the Council will be submitted to an extraordinary general meeting of the Branch for adoption, namely:

That advertisements of change of address, commencement or resumption of practice by members in the metropolitan area shall be limited to the Sydney morning dailies.

(4) Name Plates.

The further regulation of name plates in reference to the propriety of using them as a medium for advertising "specialties" was under consideration and was made a subject for determination by the Federal Committee as representing all the Branches. The Federal Committee at its meeting on February 8, 1922, passed the following resolution, namely:

That the Federal Committee is of opinion that it is not objectionable for a medical practitioner to indicate on his name plate the specialty in which he practises, provided that he confines his practice to that specialty and has the approval of the Council of his Branch.

Post-Graduate Courses.

It is gratifying to note that at length, after many years' effort on the part of the Council, the first Sydney University Post-Graduate Medical Course was held on January 9 to 20, 1922. In 1911 the Senate of the University first authorized courses of instruction to qualified practitioners and it will be remembered that the Senate then invited the Council to nominate one member of a committee appointed to consider and advise on the subject. The member appointed was Dr. F. P. SANDES, now Professor of Surgery, who had for several years advocated

the extension of the academical privileges of the University Medical School to practitioners. Dr. SANDES had, in fact, given post-graduate lectures and demonstrations in surgical anatomy and Professor D. A. WELSH and Dr. H. G. CHAPMAN, now Professor of Physiology, had organized classes of practitioners for special study in pathology and physiological chemistry. In this way pioneer work was done and a foundation laid for a more extended undertaking. It is probable that, but for the outbreak of the war in 1914, general post-graduate teaching would have been instituted earlier. After the war the matter was revived by the Council, with the result that, as announced in the last Report of the Council, the Dean of the Faculty of Medicine, Professor A. E. MILLS, invited the Council to draft proposals for adoption by the Faculty of Medicine. In due course a syllabus was drawn up and the Senate directed the University Extension Board to administer the course. Seventy-nine members of the profession, including eight from other States and twenty-six from country places of New South Wales, subscribed and great satisfaction was expressed with the choice of subjects and the manner in which they were presented. On the invitation of the Dean of the Faculty, the Council has had the 1923 course under consideration.

Legislation.

A deputation of members of the Council was received by the Minister for Public Health and Motherhood on November 3, 1921, and explained to him the urgent need which existed for legislation for the registration and supervision of midwives.

The Minister recognized the importance of the proposal and requested that members of the Council should confer with officers of his Department with the object of considering whether adequate provision for the registration and supervision of midwives could be embodied in a Nurses' Registration Bill already drafted which was waiting to be introduced to Parliament.

After some progress had been made the conference was suspended, pending the passing of the *Public Health (Amendment) Act, 1921*, and has not yet been resumed.

Reorganization of Navy and Army Medical Services.

At the instance of the Council, a motion was submitted to the Federal Committee to the effect that there should be one medical service to provide for the medical needs of the Navy, the Army and the Air Force. It is understood that the proposal is still under consideration by other Branches and will be further dealt with by the Federal Committee in due course.

Australasian Medical Congress (British Medical Association).

On the invitation of the Federal Committee and the General Committee of Congress, steps have been taken by the Council for the nomination of members in New South Wales as Presidents and Vice-Presidents of Sections of Congress at the First Session to be held in Melbourne in 1923. In regard to the date of the Inaugural Meeting of Congress, it is expected that the date fixed by the Federal Committee in February last, namely, February 12, 1923, will be changed to November 12, 1923.

Dr. F. BROWN CRAIG, 139, Macquarie Street, Sydney, has kindly undertaken the important and arduous position of Honorary Local Secretary of Congress for New South Wales. His experience as the holder of the same office for the Australasian Medical Congress (1920), Brisbane, which he filled with so much distinction to himself and so much satisfaction to his colleagues in this State, will, it is hoped, make his duties easier to him on this occasion.

Relationship Between the Overseas Branches and the Parent Association.

It is satisfactory to note that the difficulties which stood in the way of amending the Constitution, so as to allow of Branches being corporate bodies, have been removed and that the Representative Body, at its Annual Meeting at Newcastle-upon-Tyne in July, 1921, authorized the preparation of the necessary amendments to enable overseas Branches to incorporate. In this connexion, a fuller understanding of the position of the Branches in Australia on

W. H. CRAGO,
Honorary Treasurer.

would be taken to heart and that Dr. Barrington's work would bear ample fruit. He referred to the tact which Dr. Barrington had brought to his office and to the dignity and grace that he always displayed. On no occasion was this more evident than at the meeting of the Branch when the roll of honour had been unveiled. There were times when the members discussed matters, such as lodge contracts, that were of greater interest to the general practitioner than to men like the retiring President. But even on these occasions Dr. Barrington had displayed his wonted tact and had worn his velvet gloves.

The motion was carried by acclamation.

Election of Office-Bearers.

THE PRESIDENT announced the result of the election of the office-bearers and members of the Council:

President: DR. T. W. LIPSCOMB.

Vice-President: DR. W. F. LITCHFIELD.

Members of the Council: DR. GEORGE ARMSTRONG, DR. J. E. V. BARLING, DR. FOURNESS BARRINGTON, DR. C. B. BLACKBURN, O.B.E., DR. A. J. BRADY, DR. W. H. CRAIG, DR. F. BROWN CRAIG, DR. ANDREW DAVIDSON, DR. J. A. DICK, C.M.G., DR. SYDNEY JAMIESON, DR. C. H. E. LAWES, DR. W. C. MCCLELLAND, DR. R. J. MILLARD, C.M.G., C.B.E., PROFESSOR A. E. MILLS, DR. A. A. PALMER, DR. S. A. SMITH, DR. R. H. TODD and DR. R. B. WADE.

A vote of thanks was accorded the Scrutineers, DR. A. J. ASPINALL, DR. G. BELL, DR. A. L. J. S. BRANDON, DR. J. G. EDWARDS, DR. A. M. GLEDEN, DR. H. S. MARSH, DR. H. A. RIDLER and DR. A. H. TERBUTT.

On the motion of DR. CRAIG, seconded by DR. W. C. MCCLELLAND, DR. F. W. HALL and DR. A. M. GLEDEN were elected Auditors for the ensuing year.

DR. T. W. LIPSCOMB moved that DR. SINCLAIR GILLIES be appointed the Representative of the Branch in the Representative Body for the year 1922-1923. He also proposed that DR. J. W. DUNBAR HOOPER, a distinguished member of the Victorian Branch, be asked to accept the position of Deputy Representative.

The motion was seconded by DR. F. BROWN CRAIG and carried.

Reference was made to the invitation of SIR WILLIAM MACEWAN, F.R.S., the President-Elect of the British Medical Association, to the Branch to nominate representatives to attend the Annual Meeting to be held at Glasgow in July, 1922.

The meeting determined to appoint SIR JARVIE HOOD, DR. SINCLAIR GILLIES, DR. J. C. DOUGLAS and DR. CHARLES MACLAURIN.

The Medical Benevolent Fund of New South Wales.

In the absence of SIR HERBERT MAITLAND, the Honorary Secretary of the Medical Benevolent Fund of New South Wales, DR. R. H. TODD read the Financial Statement and moved that it be received. He also moved that the members of the Committee be re-appointed for the year 1922. The Trustees are DR. ROBERT FAITHFULL and DR. F. W. HALL, the members of the Committee, DR. F. W. HALL and DR. J. MACDONALD GILL, the Honorary Secretary SIR HERBERT MAITLAND and the Honorary Treasurer, DR. R. L. FAITHFULL. The motion was carried.

The Financial Statement will be found below.

Induction of President.

DR. FOURNESS BARRINGTON, in vacating the chair, referred to the scientific and other qualities of DR. T. W. LIPSCOMB and stated that he was full of confidence and assurance that he would maintain the best traditions of the New South Wales Branch of the British Medical Association of which he was President.

TASMANIAN BRANCH.

THE ANNUAL MEETING OF THE TASMANIAN BRANCH was held in the rooms of the Royal Society of Tasmania, Hobart, on February 10, 1922, DR. R. G. SCOTT, the President, in the chair.

Election of Office-Bearers.

The following were elected office-bearers and members of the Council for the ensuing year:

President: DR. G. H. HOGG.

President-Elect: DR. G. SPROTT.

Vice-President: DR. W. W. GIBLIN, C.B., V.D.

Members of Council: DR. R. G. SCOTT, DR. G. E. CLEMONS, DR. T. C. BUTLER, DR. J. SPRENT, M.C., and DR. D. H. E. LINES.

Honorary Treasurer: DR. H. W. WEBBER.

Honorary Secretary: DR. E. BRETTINGHAM-MOORE.

Annual Report.

The Annual Report of the Council was read, received and adopted:

ANNUAL REPORT FOR 1921.

THE COUNCIL have the honour to present the following report for 1921:

THE MEDICAL BENEVOLENT FUND OF NEW SOUTH WALES.

The Treasurer in Account with the New South Wales Benevolent Fund.

Dr.—1921.	£ s. d.	CR.—1921.	£ s. d.
Balance Brought Forward from March 31, 1921	174 17 1	Money Disbursed to a Deserving Case, as Directed by Committee	6 0 0
Subscriptions from March, 1921, to March, 1922	27 8 0	Bank Fees	0 10 0
		Bank Exchange	0 4 6
		Bank Book	0 4 2
		Printing and Postages	6 15 9
		Balance as per Pass Book	188 10 8
	£202 5 1		£202 5 1
			£ s. d.
At Deposit in Savings Bank of New South Wales, Barrack Street, as per Pass Book, plus Interest to June 30, 1921			347 5 0
Balance at Credit Current Account, Commercial Banking Company of Sydney, Limited, Bathurst Street Branch, as per Pass Book			188 10 8
Total Credit			£535 15 8

Audited and found correct,

HARRY C. R. DARLING.

H. L. MAITLAND,
Honorary Secretary.

The membership of the Branch is now seventy-eight. Seven are new members and two have resigned.

There were ten ordinary monthly meetings, with an average attendance of eight and a half.

There were nineteen Council meetings, with an average attendance of five.

The Council have no progress re hospital matters to report. They had a special meeting with the Director of Public Health at his request and formulated a scheme which he considered would meet with many of the Government objections to their policy, but nothing came of it. The Council wish again to acknowledge the munificence and timely donation of £100 from the Home Council as an appreciation of the stand taken by the profession in Tasmania in the hospital dispute.

A number of clinical papers were arranged for by the Clinical Secretary, Dr. T. BUTLER, but in spite of these efforts the attendance of members generally continues very poor.

President's Address.

DR. R. G. SCOTT then read his address (see page 377).

At the termination of the address Dr. SCOTT introduced Dr. G. H. HOGG to the chair.

MEDICO-POLITICAL.

THE PRESCRIPTION OF HOSPITAL PHARMACOPEIA MIXTURES.

THE METROPOLITAN CHEMISTS' ASSOCIATION OF VICTORIA have recently called the attention of the Victorian Branch of the British Medical Association to a difficulty which occasionally arises in connexion with the prescription of mixtures appearing in the Melbourne Hospital Pharmacopeia. The formulae of all these mixtures are adjusted to a single dose of one ounce. Medical practitioners in private practice at times prescribe half-ounce doses of these mixtures. The pharmacists are in doubt as to whether by such a prescription it is intended that the patient shall receive one-half of the ingredients of the mixture in one tablespoonful of vehicle or whether the mixture is to be concentrated to double strength, so that in each half ounce the patient would receive the same dose of each ingredient as is contained in one ounce of the hospital pharmacopeia mixture.

The Council of the Victorian Branch considered this matter at its meeting on March 16, 1922, and resolved:

That when half an ounce is ordered the chemist be instructed to make up the mixture in half quantities.

The Council expressed the opinion that all prescriptions should be written in full. This resolution has been forwarded to the Metropolitan Chemists' Association of Victoria. Medical practitioners are therefore informed that when they prescribe a Melbourne Hospital Pharmacopeia mixture in half-ounce doses, their patients will receive only half of the dose of each ingredient.

NOTICES.

At a meeting of the Council of the Pædiatric Section of the New South Wales Branch of the British Medical Association, held on February 20, 1922, it was resolved that the first meeting of the Section should be held on April 21, 1922, at 8.15 p.m. in the Library in the B.M.A. Building. We recommend all those who are interested in children's work, to join this Section and to take part in its deliberations. The annual fee is 5s. and all members of the New South Wales Branch are eligible for membership. The Honorary Secretary of the Section is Dr. E. SELWYN HARRISON and his address is 195, Macquarie Street, Sydney.

THE COUNCIL OF THE VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION has arranged the following provisional programme of the Branch. The Scientific Com-

mittee reserves to itself the right to modify the arrangements, but it is hoped that no changes will be necessary.

May 3, 1922.

At the Walter and Eliza Hall Institute, Melbourne Hospital, at 8.30 p.m..

DR. E. H. DERRICK: "Renal Tumours."

DR. JULIAN SMITH: "Diagnosis of Renal Tumours."

DR. H. ALAN S. NEWTON: "Treatment of Renal Tumours."

June 7, 1922.

At the Walter and Eliza Hall Institute, Melbourne Hospital, at 8.15 p.m..

DR. W. J. PENFOLD will demonstrate the action of pneumococci on aromatic amino bodies.

DR. W. J. PENFOLD: "Australian Pneumococci."

DR. S. W. PATTERSON: (a) "Prognosis in Pneumonia"; (b) "Clinical Application of Serum Treatment of Pneumonia."

DR. R. L. FORSYTH will open the discussion on the serum treatment of pneumonia from clinical experience at the Children's Hospital. Papers will be illustrated by lantern slides.

July 5, 1922.

At the Alfred Hospital.

A CLINICAL MEETING will be held, of which the details will be announced later.

Correspondence.

THE METRIC OR THE IMPERIAL SYSTEM.

SIR: May I express the opinion of one who dislikes the metric system and prefers the Imperial system for common use? In my opinion THE MEDICAL JOURNAL OF AUSTRALIA should print both, as it is the organ for the whole profession in Australia and not merely for those of the more advanced (scientifically) views and it would thus inform both and consult the preferences of all its readers.

The Imperial system is in the language of the people, of whom we are and among whom we work and after one, two or three decades, as may be, of thinking in it therapeutically, it is almost impossible for the individual to translate it into the metric system; I do not mean arithmetically, but in its inner meaning. The effect of translation on the mind's appreciation may be observed in measurement as well as in literature. Error in transcription is also less liable to occur in the Imperial system. Is 0.008 gramme comparable with $\frac{1}{8}$ grain?

Perhaps medical students trained only in the metric system may get a thorough insight into it (in spite of the Imperial measures being those of every-day life); but I am sure that for us trained long ago it is better, "as we are all old fogies after 25," to enlighten our understanding by informing us of the metric equivalent of our doses on all possible occasions.

It seems to me in the clinical recording of temperatures it is an advantage to have a range of 98.4° F. to 104° F., instead of from 37° C. to 40° C., i.e., nearly six instead of three degrees.

It would be interesting to know in how many papers you have to make the translation from Imperial to metric system in order to conform to the JOURNAL'S ideals instead of to the author's.

To me, also, it does not seem a minor matter that one is made to say that she has ordered grammes where she really ordered grains—it does not represent the actual facts. Pray pardon this reactionary letter!

Yours, etc.,

MARY C. DE GARIS, M.D., B.S. (MELB.).

"Barwon Chambers," 98, Moorabool Street,
Geelong, March 25, 1922.

¹ The "JOURNAL'S ideals" in the instance of the adoption of metric weights, measures and thermometry originated in the action taken by three Australian Branches of the British Medical Association.

SIR: The leading article in your last issue on the metric system was very opportune. The practical application of the metric system, however, is hampered by the fact that in New South Wales it is technically illegal. The Weights and Measures Office refuse to stamp weights and measures in the metric system. To conform with legal requirements, therefore, a dispensing chemist, receiving a prescription in the metric system, should translate it into the Imperial system and dispense it with stamped weights and measures of that system.

Yours, etc.,

JOHN MACPHERSON.

"Wyoming," 175, Macquarie Street,
Sydney, March 28, 1922.

Books Received.

ANDERSON STUART, M.D., by William Epps; 1922. Sydney: Angus & Robertson, Limited; Demy 8vo., pp. 177, with 16 illustrations and four cartoons. Price: 21s. net.

Medical Appointments.

DR. A. MURRAY WILL (B.M.A.) has been appointed to act as an Official Visitor at Gladesville and Callan Park Hospitals for the Insane, New South Wales, during the absence of SIR JARVIE HOOD.

DR. F. P. QUIRK (B.M.A.) has been appointed Government Medical Officer at Condobolin, New South Wales.

DR. T. R. JAGGER (B.M.A.) has been appointed Medical Officer of Health by the West Guildford Road Board, Western Australia.

THE appointment of DR. G. M. HEYDON (B.M.A.), DR. F. T. WHEATLAND (B.M.A.), DR. K. R. MOORE (B.M.A.), DR. J. BROWN (B.M.A.) and DR. R. D. MCINTOSH (B.M.A.) on probation as Medical Officers to the Laboratories under the control of the Federal Department of Health has been announced in the *Commonwealth of Australia Gazette* of March 23, 1922.

DR. E. E. WEBSTER (B.M.A.) has been appointed Certifying Medical Practitioner in the District of Brighton, Victoria, for the purposes of the *Factories and Shops Acts*.

DR. H. ROGERSON (B.M.A.) has been appointed Acting Medical Superintendent at the Hospital for the Insane, Yarra Bend, Victoria.

DR. J. S. A. ROGERS has been appointed a Junior Medical Officer, Hospitals for the Insane, Victoria.

THE COMMISSION OF PUBLIC HEALTH IN VICTORIA has appointed the following as places for public vaccination at stated hours: The surgery and the rooms of DR. J. C. CRAIG (B.M.A.) at Edenhope and at Apsley respectively; the surgery of DR. T. M. HENDRY (B.M.A.) at Gorokey; the surgery and the rooms of DR. B. SHEINKIN (B.M.A.) at Toora and at Welshpool respectively; the surgery of DR. P. A. STEVENS (B.M.A.) at Preston.

Medical Appointments Vacant, etc..

For announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xviii.

COMMONWEALTH PUBLIC SERVICE: Vacancies for Quarantine Officers at Adelaide and Fremantle.

DEPARTMENT OF PUBLIC INSTRUCTION, VICTORIA: Medical Officer.

IPSWICH HOSPITAL, QUEENSLAND: Junior Medical Officer.

MACKAY DISTRICT HOSPITAL, NORTH QUEENSLAND: Resident Surgeon.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C.

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney	Australian Natives' Association Ashfield and District Friendly Societies' Dispensary Balmmain United Friendly Societies' Dis- pensary Friendly Society Lodges at Casino Leichhardt and Petersham Dispensary Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney Marrickville United Friendly Societies' Dispensary North Sydney United Friendly Societies People's Prudential Benefit Society Phoenix Mutual Provident Society
VICTORIA: Honorary Secretary, Medical Society Hall, East Melbourne	All Institutes or Medical Dispensaries Australian Prudential Association Pro- prietary, Limited Manchester Unity Independent Order of Oddfellows Mutual National Provident Club National Provident Association
QUEENSLAND: Hon- orary Secretary, B. M. A. Building, Adelaide Street, Brisbane	Brisbane United Friendly Society Insti- tute Hampden District Hospital Stannary Hills Hospital
SOUTH AUSTRALIA: Honorary Secretary, 3, North Terrace. Adelaide	Contract Practice Appointments at Ren- mark Contract Practice Appointments in South Australia
WESTERN AUS- TRALIA: Honorary Secretary, 6, Bank of New South Wales Chambers, St. George's Terrace, Perth	All Contract Practice Appointments in Western Australia
NEW ZEALAND (WELLINGTON DIVI- SION): Honorary Secretary, Wellin- gton	Friendly Society Lodges, Wellington, New Zealand

Diary for the Month.

- APR. 11.—New South Wales Branch, B.M.A.: Ethics Committee.
APR. 12.—Western Australian Branch, B.M.A.: Council.
APR. 12.—Melbourne Pædiatric Society.
APR. 13.—Brisbane Hospital Clinical Society: Meeting.
APR. 14.—Queensland Branch, B.M.A.: Council.
APR. 14.—South Australian Branch, B.M.A.: Council.
APR. 15.—Northern Suburbs Medical Association, New South
Wales.
APR. 18.—New South Wales Branch, B.M.A.: Executive and
Finance Committee.
APR. 19.—Western Australian Branch, B.M.A.: Branch.
APR. 21.—Eastern Suburbs Medical Association, New South
Wales.
APR. 21.—Western Medical Association, Cowra, New South
Wales.
APR. 25.—New South Wales Branch, B.M.A.: Medical Politics
Committee: Organization and Science Committee.
APR. 26.—Victorian Branch, B.M.A.: Council.
APR. 27.—South Australian Branch, B.M.A.: Branch.
APR. 27.—Brisbane Hospital for Sick Children: Clinical
Meeting.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor," THE MEDICAL JOURNAL OF AUSTRALIA, B.M.A. Building, 30-34, Elizabeth Street, Sydney. (Telephone: B. 4635.)